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

Prepared for
COMPASS PTN

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

Kim Blanton Story

https://www.youtube.com/watch?v=sikdSUnBmos

Anthony T. Washington Sr.
12/16/1949 – 08/13/2009
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*
PFE Now Embedded in CMS Quality Strategy as “Person” & Family Engagement

**Goals**

- Make care safer
- Strengthen person and family centered care
- Promote effective communications and care coordination
- Promote effective prevention and treatment
- Promote best practices for healthy living
- Make care affordable

**Foundational Principles**

- Enable Innovation
- Foster learning organizations
- Eliminate disparities
- Strengthen infrastructure and data systems

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**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

CMS Systems Approach: Safety Across the Board
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

Minnesota HEN “Pattern
PFE and Campaign Outcomes

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

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### The TCPI Change Package Structure: Expanded Driver Diagram

<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>
<tbody>
<tr>
<td>Intended Results</td>
<td></td>
<td></td>
<td></td>
<td>Actionable</td>
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</tbody>
</table>

*Broad concepts that prompt specific change ideas derived from site visits/ high performers*
Drivers: Essential to Achieving TCPI Aims

TCPI AIMS/GOALS

1) Practice Transformation. Evidence of a culture of quality where the vision is clear and data is used to drive continuous improvement in quality, outcomes, cost of care and patient, family and staff experience.

2) Effective solutions moving to scale. Evidence of practice spreading effective improvement strategies to full scale for the entire population under its care.

3) High Clinical Effectiveness: Practice is effective in bringing all patient segments to their health status goals.

4) Reduced Avoidable Hospital Use: Rates of readmission and unnecessary admissions for practice’s patients have been reduced.

5) Reduced Unnecessary Testing & Procedures: Practice demonstrates a reduction in unnecessary testing and in the use of the ED by its patient population.

6) Reduced costs: Practice controls its internal costs as well as other elements of total cost of care.

7) Documented Value: Practice can articulate its value proposition and increases participation in available value-based payment agreements.

<table>
<thead>
<tr>
<th></th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and Family-Centered Care Design</td>
<td>1.1 Patient &amp; family engagement</td>
<td>2.1 Engaged and committed leadership</td>
</tr>
<tr>
<td></td>
<td>1.2 Team-based relationships</td>
<td>2.2 Quality improvement strategy supporting a culture of quality and safety</td>
</tr>
<tr>
<td></td>
<td>1.3 Population management</td>
<td>2.3 Transparent measurement and monitoring</td>
</tr>
<tr>
<td></td>
<td>1.4 Practice as a community partner</td>
<td>2.4 Optimal use of HIT</td>
</tr>
<tr>
<td></td>
<td>1.5 Coordinated care delivery</td>
<td></td>
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<td></td>
<td>1.6 Organized, evidence based care</td>
<td></td>
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<tr>
<td></td>
<td>1.7 Enhanced Access</td>
<td></td>
</tr>
<tr>
<td>Continuous, Data-Driven Quality Improvement</td>
<td>3.1 Strategic use of practice revenue</td>
<td></td>
</tr>
<tr>
<td>Sustainable Business Operations</td>
<td>3.2 Staff vitality and joy in work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Capability to analyze and document value</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.4 Efficiency of operation</td>
<td></td>
</tr>
</tbody>
</table>

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
Compass Practice Transformation
Network 2016 Training and Kick-off

TCPI PFE National Strategy

Strategic Management Plan

- 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

Kansas Healthcare Collaborative
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

1. Family engagement in care
2. Teach back
3. Warm hand-offs
4. Medication safety interventions

- Patient and family advisory councils
- Shared decision-making
What is the QIN-QIO Campaign for Meds Management (CMM)?

CMM a collaborative informed and driven by the experiences of medication users successfully self-managing their medication use.

In 2016 CMM will develop and pilot test several innovative self-management methods for safe medication use in a number of beneficiary/provider communities.

The tested and proven self-management innovations will be ready in 2017 for spread community by community through a collaborative effort with (a) health care provider organizations and (b) community based organizations and (c) membership organizations.

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.

National Medication Safety Network formed to continue spread and improvement of 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
- …

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
CMM Change Package to include Tools Assembled from Existing Toolkits

• Examples:
  • *New Health Partnerships Information for People with Chronic Conditions Self-Management Support*, 2011, IHI

CMM Change Package to include Tactics Drawn from Case Studies

C. Stories of Assessment and Support
D. Stories of Patient and Family Self-Management
E. Tools Pulled from Existing Self-Management literature
CMM Story Development (to date)

<table>
<thead>
<tr>
<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>
</tr>
<tr>
<td>Teresa</td>
<td>Breast cancer</td>
<td>H/W, Neighbor</td>
<td>Neighbor, 1.5 years</td>
</tr>
<tr>
<td>Richard</td>
<td>Heart valve replacement</td>
<td>Individual</td>
<td>Individual</td>
</tr>
<tr>
<td>Gerry, Kathy</td>
<td>Dementia</td>
<td>Mom, Daughter</td>
<td>Family with assisted living</td>
</tr>
</tbody>
</table>

Range of Self-Management Strategies

### IOM Operating Definitions

**Patient Self-Management**

“…the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions.”

**Collaborative Self-Management Support**

“…the systematic provision of education and supportive interventions by health care staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.”

### Collaborative Self-Management Support – Practice Core Competencies

- 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)

Supporting Self-Management: 5 As
©World Health Organization 2004

**Assess:** Beliefs, Behaviors & Knowledge
1. List specific goals.
2. List barriers and strategies.
3. Specify follow-up plan.
4. Share plan

**Advise:** Provide specific information about health risks and benefits of change.

**Agree:** Collaboratively set goals based on patient's interest & confidence in their ability to change behaviors(s)

**Assist:** Identify personal challenges, strategies, problem-solving techniques, and social environmental support

**Arrange:** Specify plan for follow-up (e.g., visits, phone calls, mailed reminders)

[http://www.who.int/diabetesactiononline/aboutWHO%205A%20ppt.pdf]
**Motivational Interviewing (MI)**

**MI Goals**
- Directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence
- *Brief MI* can be implemented in most health care settings
- Training in the technique is needed

**MI How To**
- Identify patient’s stage/attitude toward change
- Help patient articulate pros & cons of change
- Empathize and empower the client to take steps toward change

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**MI DARN CAT Tool**

Helping patients with chronic conditions overcome barriers to self-care

*2012 - The Nurse Practitioner, 13 Mar 2012, v37, No. 3, pp 38–39*

- **D–Desire.** Why do you want to make this change in how you take your medication?
- **A–Ability.** If you decide to make this change, how would you do it?
- **R–Reasons.** What are the most important benefits that you think you’ll see from taking your medication better?
- **N–Need.** How important is it to you to make this change?
- **C–Commitment.** What do you think you will do?
- **A–Activating.** What are you ready to do?
- **T–Taking steps.** What are you already doing to be healthy?
If you have DIABETES, here are some things you can talk about with your health care provider.

Choose to talk about changing any of these and add other concerns in the blank circles.

- Blood glucose monitoring
- Taking medications to help control blood sugar
- Taking insulin
- Physical Activity
- Diet
- Losing weight
- Daily foot care
- Depression
- Smoking

Adapted from Stott et al., Fam Practice, 1995 by Barbara Kondilis of the RI Chronic Care Collaborative

Patient and Care Partner Tools

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

CMM Guides Content

**Physician/Office Guide**
- Establish the infrastructure to make self-management possible
- Secure assessment of patient & family readiness and ability to self-manage meds.
- Enable self-management with support, education, check-in
- Track the process and results of self-management by the patient and family

**Patient/Family Guide**
- Seek assessment of your readiness for med self-management
- Find and embrace support to master the medication program
- Build your personal medication self-management program
- Keep the med program visible and current
CMM Guides Content

**Payer Guide**
- Segment patients by high risk of medication breakdown
- Get commitment from physician to pursue med self management
- Link patient and physician up with certified assessor.
- Track the process and results of self-management by patient and family

**Assessment & Support Guide**
- Assess patient command of the condition and the medication program.
- Assess family structure and readiness for self-management.
- Others TBD

**Key Take-Away (1): Why is the Partnership between Clinicians and Patients Important?**

Patient-Centered Care and the Systems Approach are emergent mental models in healthcare now shifting the relationship paradigm of “active physician/compliant patient” to a new normal of collaborative partnership.

Accumulating research findings that patients who are proactive partners achieve better outcomes is fueling this shift.
Key Take-Away (2): *Why is the Partnership between Clinicians and Patients Important?*

The Institute of Medicine and other healthcare transformation thought leaders champion this shift, which is now being embedded by CMS in policy and payment reform. CMS is already in the early stages of measuring PFE and its role in producing safer and higher quality care for lower cost.

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Key Take-Away (3): *Why is the Partnership between Clinicians and Patients Important?*

These shifts in thinking, policy and payment will have particular impact in the ambulatory care “ecosystem” including physician practice settings, where there is both less opportunity for providers to closely supervise patients and great untapped potential to engage patients and their family members as true partners.

Increased Self-Management Support and integration of patient and family input into system re-design and improvement work will help physician practices realize the potential for PFE to be the “blockbuster drug of the 21st Century.”
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.

Tom Evans, Iowa Healthcare Collaborative

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**Reaching a Stretch Goal by Starting with the End in Mind** (watch the timer)

https://www.youtube.com/watch?v=lNnr7Grj1Eo