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.

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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

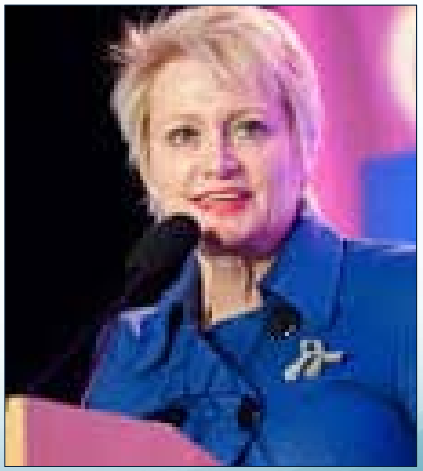
Key Terms

- 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)

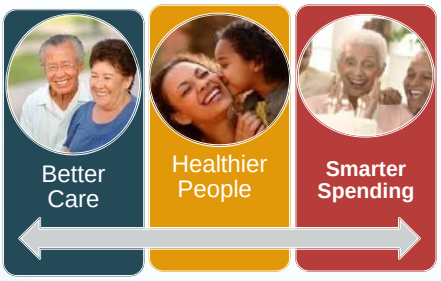
Rx For The 'Blockbuster Drug' Of Patient Engagement, *Health Affairs* 32(2), 202 (2013)

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.

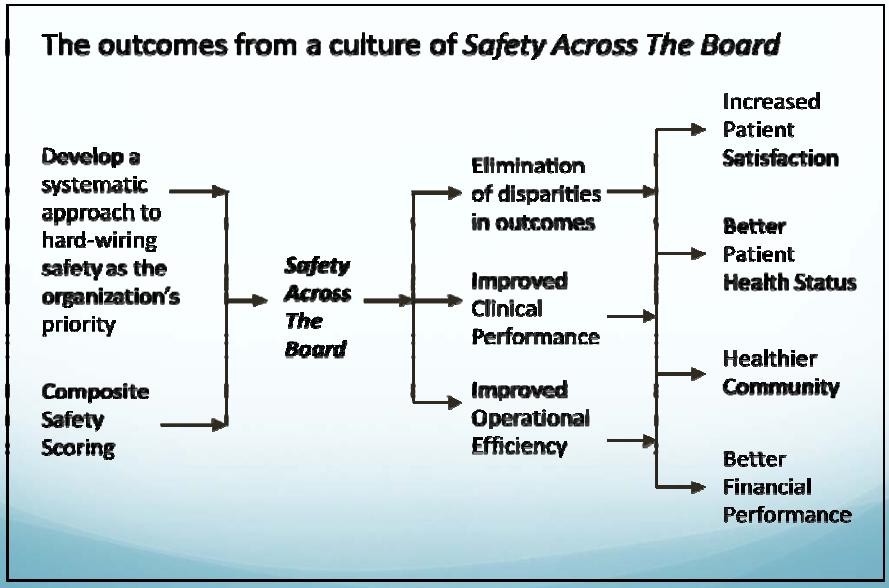
PfP Safety Across the Board Initiative

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)

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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)

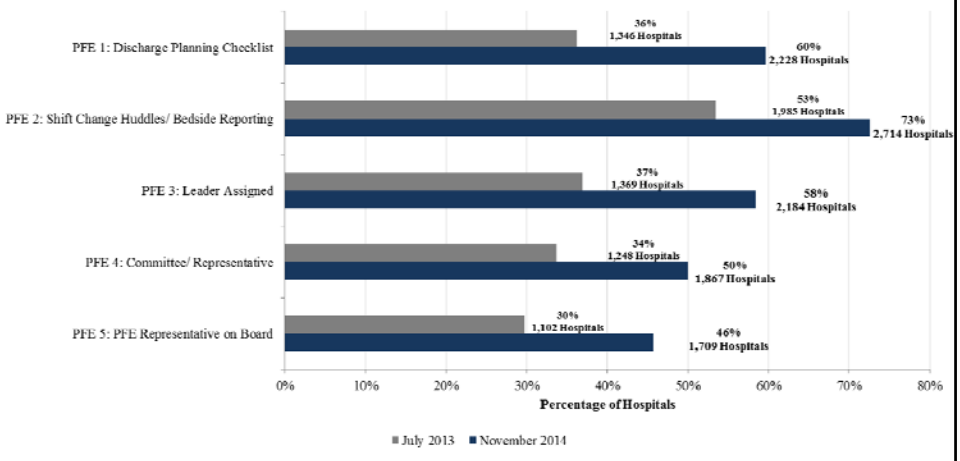
Partnership for Patients: Better Outcomes, Lower Costs

GOALS:

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

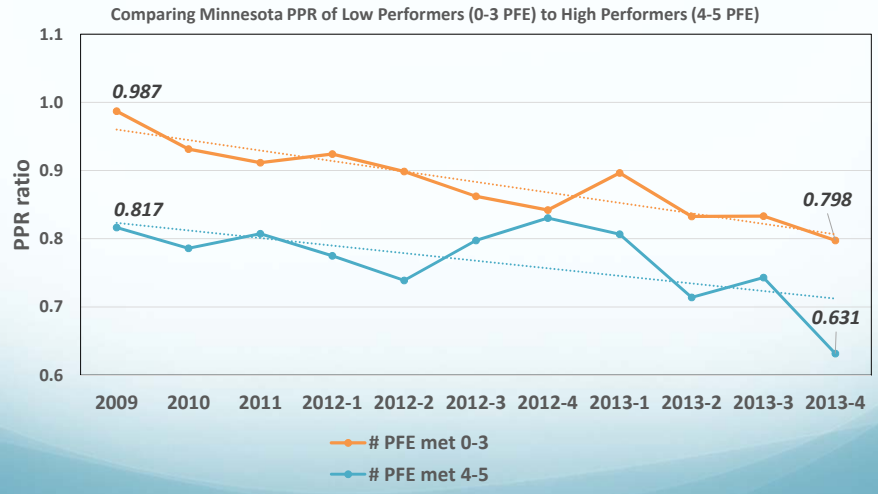
20% **Reduction in 30-Day Readmissions**
1.6 Million Patients Recover without Readmission

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



Source: HEN-extracted Z-5 spreadsheets July 2013 and November 2014.

Minnesota HEN "Pattern PFE and Campaign Outcomes



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?

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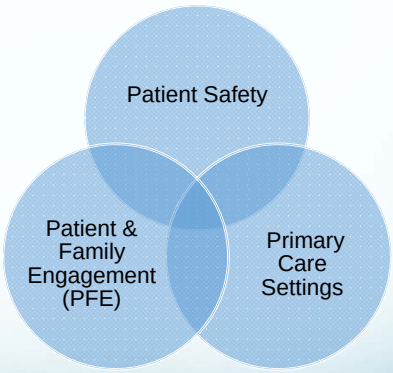
AHRQ Environmental Scan

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

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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

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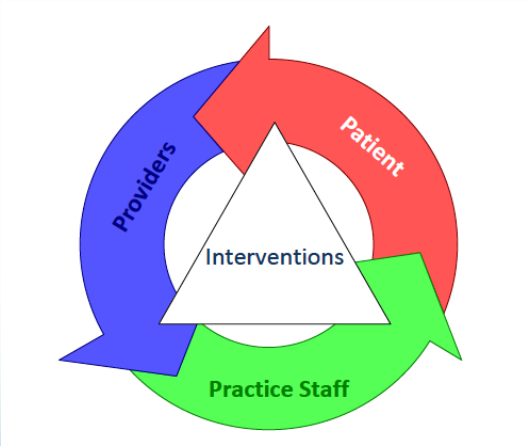
AHRQ Guide Model for Advancing PFE in Primary Care



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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

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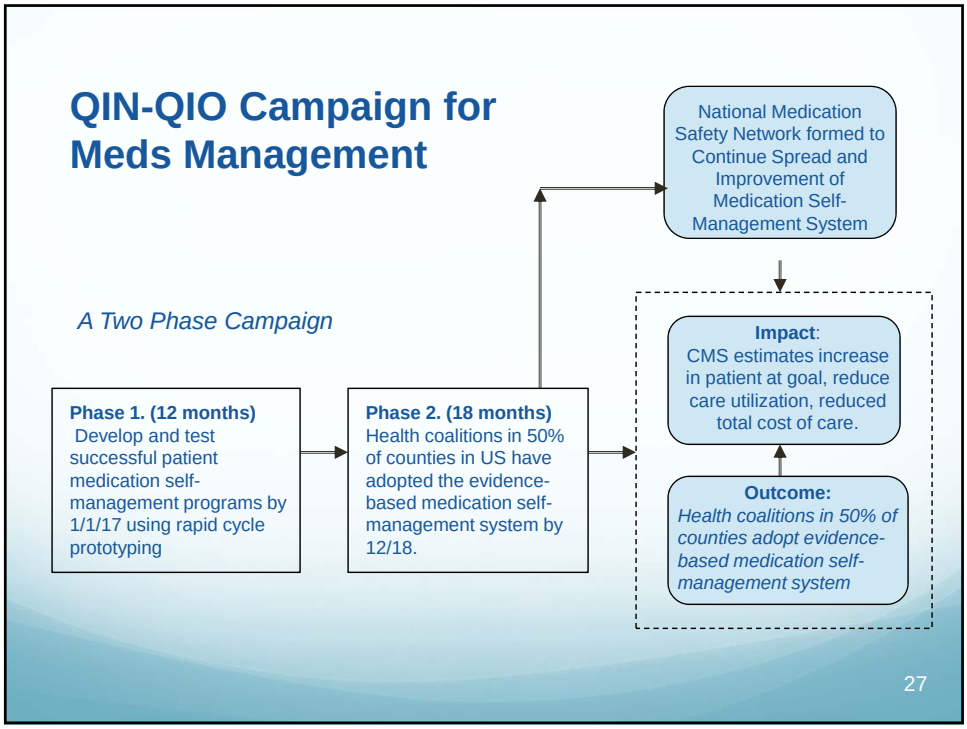
QIN-QIO Campaign for Meds Management
National Medication Safety Network formed to Continue Spread and Improvement of Medication Self-Management System
A Two Phase Campaign
Impact: CMS estimates increase in patient at goal, reduce care utilization, reduced total cost of care.
Phase 1. (12 months) Develop 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.
Outcome: Health coalitions in 50% of counties adopt evidence-based medication self-management system
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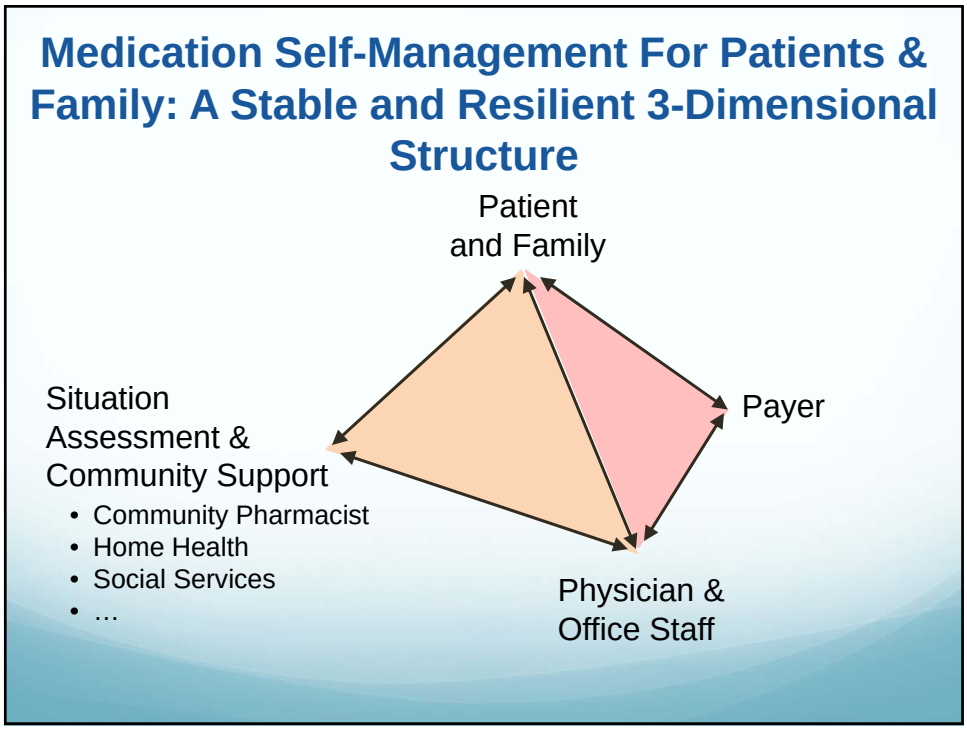
Medication Self-Management For Patients & Family: A Stable and Resilient 3-Dimensional Structure
Patient and Family
Payer
Physician & Office Staff
Situation Assessment & Community Support
• Community Pharmacist
• Home Health
• Social Services
• …

CMM Story Development (to date)

Self-Management Of Medication: Cases and Faculty				
	Medical Condition	Caregiver Situation	Med Self Manager	Scope, Depth of Med Management
Bruce, Connie	Stroke, kidney transplant	Husband, Wife (H/W)	Husband	Personal system manages med flow, effects, & health
Teresa	Breast cancer	H/W, Neighbor	Neighbor, 1.5 years	Manage flow of meds
Richard	Heart valve replacement	Individual	Individual	New test process. Manage med level and own health
Gerry, Kathy	Dementia	Mom, Daughter	Family with assisted living	Created controlled situation Manage flow of meds

Four Guides in the CMM Change Package

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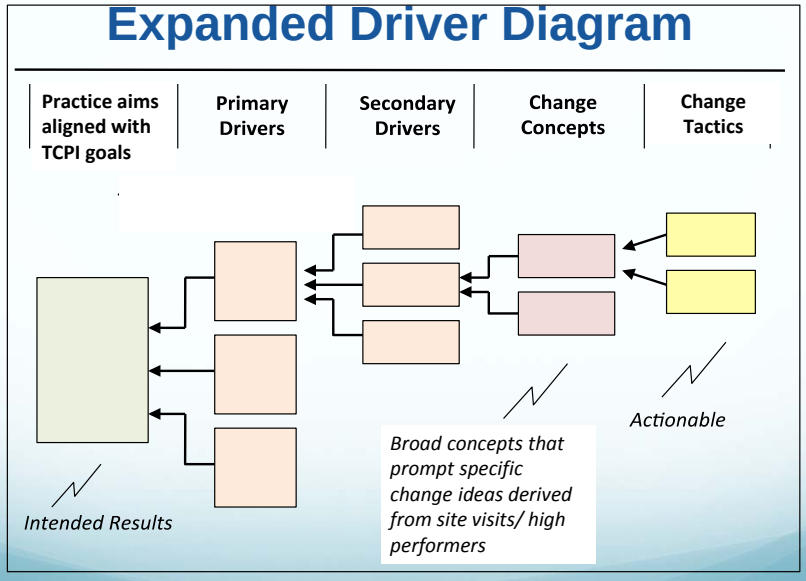
A. Guide for Physicians

B. Guide for Payers

C. Guide for Assessment and Support

D. Guide for Patients and Families

The TCPI Change Package Structure: Expanded Driver Diagram



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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.**

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

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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

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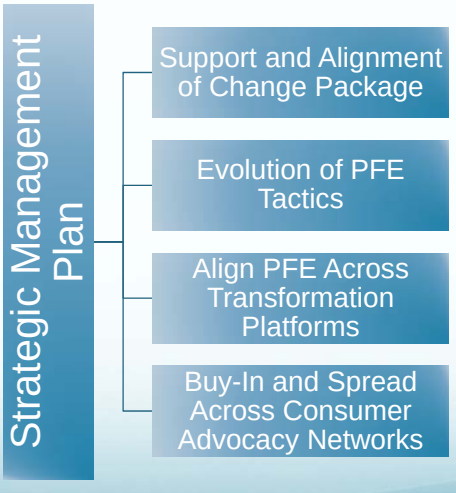
TCPI PFE National Strategy



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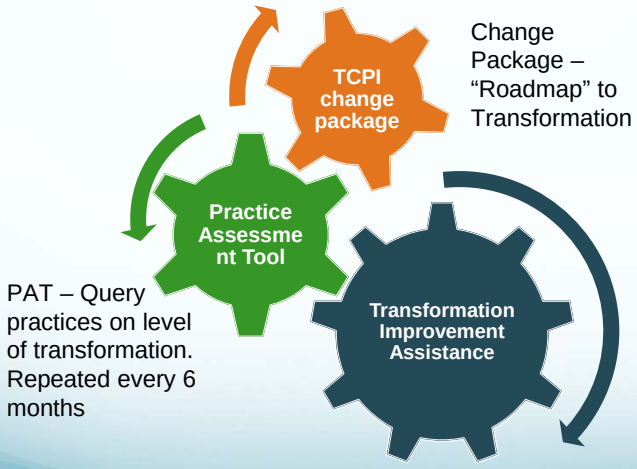
PFE Comes Together in Overall TCPI Improvement Process



Change Package – "Roadmap" to Transformation

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.

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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*

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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*

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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*

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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*

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

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.

Tom Evans, Iowa Healthcare Collaborative

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

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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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