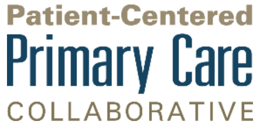
Patient, Family, and Clinician Partner Training Guide

PCPCC Support & Alignment Network for Patient, Caregiver & Community Engagement



WELCOME

On behalf of the Patient-Centered Primary Care Collaborative Support & Alignment Network, we are thrilled to welcome you to our Patient, Family and Clinician Partner Training. This day is dedicated to providing patient advisors and their clinician partners with the knowledge, tools, and skills required to drive practice transformation in primary and ambulatory care settings.

It is a privilege to have such dedicated patient advisors, community partners, clinicians and other health care professionals join us to learn more about promoting meaningful partnerships in quality improvement and community collaboration with care teams in primary and ambulatory care settings.

Thank you for all you do to advance patient- and family-centered care!

Jacinta Smith, MPH
SAN Program Manager
Patient-Centered Primary Care Collaborative

Mary Minniti, BS, CPHQ
Senior Policy & Program Specialist
Institute for Patient-and Family-Centered Care

Beverley Johnson
President & CEO
Institute for Patient-and Family-Centered Care

Kelly Parent, BS
Program Specialist for Patient and Family Partnerships
Institute for Patient-and Family-Centered Care

Suzi Montasir, MPH
Technical Advisor, Clinical Integration of Chronic Disease Programs
YMCA of the USA

Tim McNeill, RN, MPH
Director, Clinical Integration
YMCA of the USA

Matt Longjohn, MD, MPH
National Health Officer & Vice President for Evidence-Based Health Interventions and Community Integrated Health
YMCA of the USA

Jill Harrison, PhD
Director of Research
Planetree

Hala Durrah, MTA
Patient Family Centered Care Advocate & Consultant

Patient, Family, and Clinician Partner Training Agenda

Friday, November 11, 2016
Location: Constitution Ballroom A

7:30 – 8:00 AM
Networking Breakfast

8:00 – 8:20 AM
Welcome & Conference Overview
The training will open with a brief discussion around various session topics from the PCPCC Annual Conference. Participants will also receive a general synopsis of what to expect throughout the training day.

Moderator:
Hala Durrah, MTA, Family Caregiver; Patient Family Centered Care Advocate & Consultant

8:20 – 8:50 AM
The BIG Picture: The Quadruple Aim of Healthcare Reform, the Transforming Clinical Practices Initiative (TCPI), and Why We Need Patient, Family & Community Partners
Participants will be provided with an overview of what is happening in health care reform using the Quadruple Aim as a framework, identify stakeholders among PCPCC membership involved in this movement, and learn about other federal initiatives, including the Transforming Clinical Primary Initiative.

Speaker:
Beverley Johnson, IPFCC CEO & President; PCPCC Board Member

8:50 – 9:10 AM
Role of the PCPCC SAN Grant in Helping Achieve TCPI Goals
The PCPCC, Institute for Patient- and Family-Centered Care (IPFCC), Planetree, and YMCA of the USA have joined forces to form the PCPCC's Support and Alignment Network (SAN). Primary/ambulatory care practices and enrolled clinicians participating in TCPI have access to technical assistance provided by the PCPCC SAN to help guide practice transformation through patient engagement and quality improvement. In this session, participants will discover the opportunities each organization is offering and how they can benefit from these resources.

Speakers:
Jacinta Smith, **MPH**, PCPCC SAN Program Manager
Jill Harrison, **PhD**, Director of Research, Planetree
Matt Longjohn, **MD, MPH**, National Health Officer & VP for Evidence-Based Health Interventions & Community Integrated Health, YMCA of the USA
Mary Minniti, **BS, CPHQ**, Senior Policy & Program Specialist, IPFCC

9:10 – 9:40 AM
Break Out Session: Why We Are Here
Participants will 1) identify challenges related to building patient and practice/clinician partnerships and 2) discuss steps that may be taken to strengthen partnerships and improve the quality of care delivery.

Facilitator:
Hala Durrah, MTA, Family Caregiver; Patient Family Centered Care Advocate & Consultant

9:45 – 10:00 AM
Break

10:00 – 11:15 AM

Developing Patient and Family Partnerships in Practice Transformation

This session will instruct participants on how to transform primary/ambulatory care practices into high quality and satisfying experiences through partnership with patients and families at the point-of-care and beyond. Expert faculty will share best practices demonstrated across primary/ambulatory care programs and highlight the roles patients and family caregivers can play to improve quality and safety.

Speakers:
Mary Minniti, **BS, CPHQ**, Senior Policy and Program Specialist, IPFCC
Kelly Parent, **BS**, Program Specialist for Patient and Family Partnerships, IPFCC

11:15 AM – 12:15 PM
Break to Grab Lunch in DC
12:15 – 12:45 PM
Mechanisms for Establishing Successful Partnerships Between Practices And CBO; The YMCA's DPP and Other Examples

Our partners from the YMCA will highlight the importance of clinical-integration of clinical practices and community-based organizations (CBOs) as successful partnerships to support patients and achieve practice improvements. Participants will learn about the incentives and roles of the clinical practice and the CBO. Program outcomes from the YMCA's Diabetes Prevention Program (DPP) and its planned expansion through Medicare will also be discussed.

Speaker:
Tim McNeill, **RN, MPH**, Director, Clinical Integration, YMCA of the USA

12:45 – 1:20 PM

Creating Partnerships Between Practices and Community-Based Organizations

This session will emphasize the importance of bidirectional communications, partnering with patients in the community, promotion and referral to evidence-based programs by practices, and key aspects of shared space arrangements. The YMCA will conclude with a presentation of their vision of Community Integrated Health.

Speaker:
Suzi Montasir, **MPH,** Technical Advisor, Clinical Integration of Chronic Disease Programs, YMCA of the USA

1:20 – 2:00 PM

Changing How We Do EVERYTHING! Moving from *FOR* Patients and Families to *WITH* Patients and Families

Participants will examine lessons learned from Planetree Designated organizations and PCORI Engagement Award to Engage Patient and Family Partners. Planetree faculty will share real-world examples to shift organizational culture and practice to prioritize and personalize patient partnerships.

Speaker:
Jill Harrison, PhD, Director of Research, Planetree

2:00 – 2:15 PM
Break

2:15 – 2:30 PM

Overview of Action Plan and Strategies/Turning Ideas into Action

Participants will receive an instructional overview on completing an action plan that includes ideas and strategies for practices/clinicians to foster partnerships with patients, family caregivers to improve care delivery and quality.

Speakers:
Jacinta Smith, MPH, PCPCC SAN Program Manager
Mary Minniti, **BS, CPHQ**, Senior Policy and Program Specialist, IPFCC

2:30 – 3:30 PM

Turning Ideas into Action

Training faculty will be assigned to various teams to help facilitate plan development. Action plans will include priorities for practice improvement based on the Practice Assessment Tool (PAT) and other quality improvement templates.

Moderators:

All training faculty

3:30 – 4:00 PM

Closing Summary

Expert faculty will join training participants in a discussion summarizing the day's activities and lessons learned.

Moderators:

Hala Durrah, MTA, Family Caregiver; Patient Family Centered Care Advocate & Consultant

Jacinta Smith, MPH, PCPCC SAN Program Manager

The BIG Picture: The Quadruple Aim of Healthcare Reform, the Transforming Clinical Practices Initiative (TCPI), and Why We Need Patient, Family & Community Partners

The BIG Picture:

The Quadruple Aim of Healthcare Reform, Transforming Clinical Practice Initiative, and Why We Need Patient, Family, and Community Partners

Beverley H. Johnson
IPFCC President and CEO

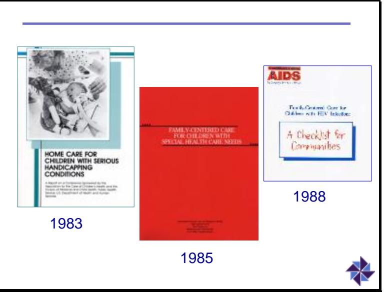
PCPCC Annual Conference
Washington, DC
November 11, 2016

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

In our time together . . .

- Develop a shared understanding of the historical evolution of patient- and family-centered care and how it relates to transforming clinical practices in ambulatory settings with patients, families, and communities.
- Describe the Triple Aim and Qradruple Aim and the roles of patient, family, and community partnerships.
- Discuss how partnerships with patients, families, and communities are a consistent theme in the change and improvement of the health care system over the last 35 years.

1980s



1990s

Patient- and Family-Centered Core Concepts

- People are treated with **respect and dignity**.
- Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.
- Patients and families are encouraged and supported in **participating in care and decision-making** at the level they choose.
- **Collaboration** among patients, families, and providers occurs in policy and program development and professional education, as well as in the delivery of care.

Patient- and family-centered care is working "with" patients and families, rather than just doing "to" or "for" them.

W. Carl Cooley, MD, Pioneer for the Medical Home

- The beginning . . .early 1990's
  - Office-Based Improvement…physician, office manager, and a family advisor.
  - Family-centered, coordinated, community-based care.
  - Medical Homes in New Hampshire with families involved from the beginning.

Office-Based Quality Improvement Center for Medical Home Improvement

Pediatricians, family medicine physicians, and families working together to assure that all children have access to family-centered, culturally competent, coordinated, comprehensive primary care (*Pediatrics*, 2002).

Quality improvement methodology
- Core team: MD, Nurse or Case Manager, and a parent.
- Rapid cycle improvement.
- Developing a system of care, tracking, and monitoring children with special needs.

www.medicalhomeinfo.org/about/ www.medicalhomeimprovement.org

Cooley, W. C., McAllister, J. W., Sherrieb, K., & Khulthau, K. (2009). Improved outcomes associated with medical home implementation in pediatric primary care. *Pediatrics, 124, 358-364.*

1999-2003

2000

Study of Communication in Outpatient Visits

When patients achieved common ground with physicians, health status improved, emotional health improved, fewer referrals and diagnostic tests needed two months after the visit.

Stewart, M., et al. The Impact of Patient-Centered Care on Outcomes, *Journal of Family Medicine*, 2000.

2003

High Plains Research Network (HPRN) Community Advisory Council, Colorado

- Since 2003, the Community Advisory Council has participated in all aspects of the HPRN research.
- An all day “boot camp” is held prior to working on a project. Projects have included:
  - Testing to Prevent Colon Cancer in Rural Colorado
  - Asthma Toolkits and Community Asthma Integration and Resources (AIR) (Asthma awareness and management)
  - Under-insurance
  - Patient-centered medical home
  - Patient harm/medical mistakes
- For further information: Westfall, J. M., VanVorst, R. F., Main, D. S., & Herbert, C. (2006). Supplemental case report: Community involvement in a practice-based research network. *Annals of Family Medicine, 4*(1), 8-14. Retrieved from http://www.annfammed.org/cgi/data/4/1/8/DC1/1

High Plains Research Network (HPRN) Community Advisory Council, Colorado (cont’d)

Connecting with the Gun Club . . .

High Plains Research Network (HPRN) Community Advisory Council, Colorado (cont'd)

"The Community Advisory Council has made our research ten times better, much more relevant to the communities we serve. In addition, it's a lot of fun to work with the Community Advisory Council."

Jack Westfall, MD, MPH

2005-2013

and continuing

Results in Marion County

WVP HEALTH AUTHORITY

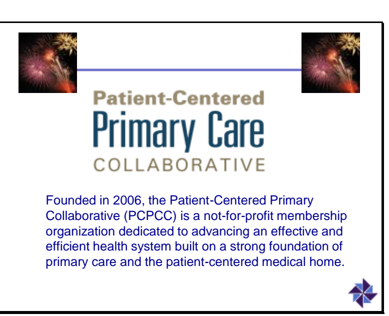
Impact of a Peer-led Substance Abuse Program for Pregnant Moms.

The number of babies taken at birth for a positive drug screen in Marion county has dropped from:

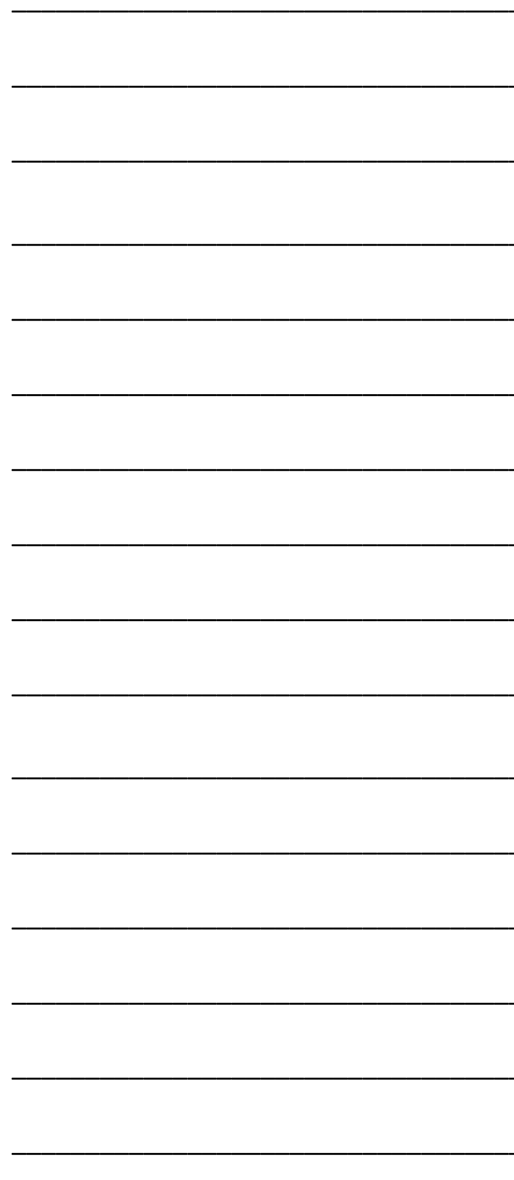
- 114 in 2005;
- 12 in 2010;
- 9 in 2011;
- 11 in 2012; and
- 10 in 2013

99.4% of babies of enrolled MOMS participants tested negative for illegal drugs at birth. The moms of the two babies who tested positive, had only been enrolled for less than a month

2006



2007



The Joint Principles for the Patient-Centered Medical Home . . . An Opportunity

- ". . . A care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. . .
- Patients actively participate in decision-making. . .
- Care is coordinated. . .in a culturally and linguistically appropriate way.
- Information technology is utilized appropriately to support . . . enhanced communication.
- Patients and families participate in quality improvement at the practice level."

2010

Health Care Reform in the United States

- A Consistent Theme of Patient and Family Engagement at all Levels
- The Affordable Care Act of 2010
  - Primary care redesign, increased access, and further integration with mental health.
  - Partnerships for Patients: Better Care and Lower costs — Reduction in preventable hospital acquired conditions and readmissions

Affordable Care Act 2010

- "The law includes provisions to communicate health and health care information clearly; promote prevention; be patient-centered and create medical or health homes; assure equity and cultural competence; and deliver high-quality care."

Source: Somers, S. A., & Mahadevan, R. (2010). *Health Literacy Implications of the Affordable Care Act. Available at* http://iom.nationalacademies.org/

2012

Triple Aim — Patient- and Family-Centered Care

Health of Populations

Patient Experience

Reducing Costs

"The most direct route to the **Triple Aim** is via patient- and family-centered care in its fullest form."

Don Berwick

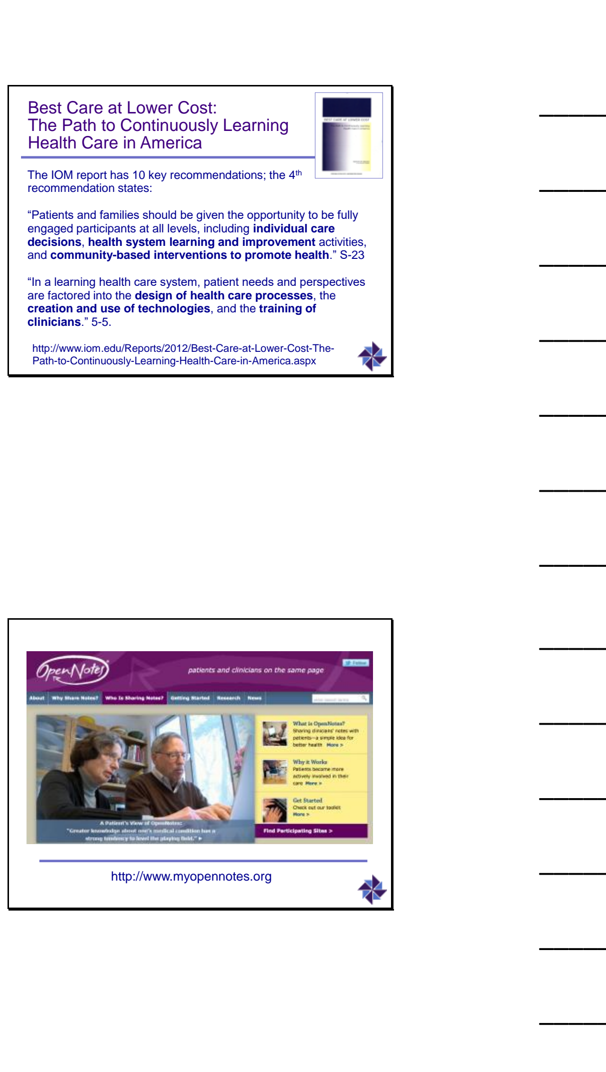
Best Care at Lower Cost: The Path to Continuously Learning Health Care in America

The IOM report has 10 key recommendations; the 4th recommendation states:

"Patients and families should be given the opportunity to be fully engaged participants at all levels, including **individual care decisions**, **health system learning and improvement** activities, and **community-based interventions to promote health**." S-23

"In a learning health care system, patient needs and perspectives are factored into the **design of health care processes**, the **creation and use of technologies**, and the **training of clinicians**." 5-5.

http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx



http://www.myopennotes.org

2013

Fort Collins Family Medicine Group Pain Clinic

A strengths-based, empowering, patient- and family-centered approach to chronic pain management.

Integration of physical health, behavioral health, and community partnerships.

Partnered with community resources for volunteer opportunities and for learning experiences for massage students.

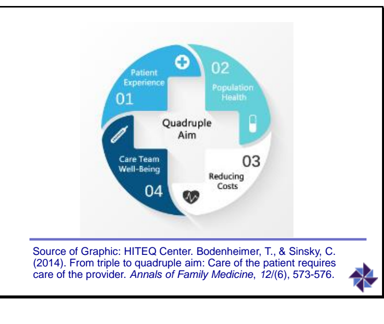
2013

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

American College of Physicians creates Center for Patient Partnership in Healthcare to advance collaboration between physicians and patients

Goal is to help patients become informed advocates and active partners in their care

2014



Source of Graphic: HITEQ Center. Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine*, *12*(6), 573-576.

VIEWPOINT

Challenges at the Intersection of Team-Based and Patient-Centered Health Care

Insights From an IOM Working Group

Matthew K. Wynia, MD, MPH
Isabelle Von Kohorn, MD, PhD
Pamela H. Mitchell, PhD, RN

"In high-functioning health care teams, patients are members of the team; not simply objects of the team's attention…"

Bruner Family Medicine Center Denver, CO

"Even when I have been up all night, I find attending the Patient and Family Advisory Board energizing."

Aaron Gale, Medical Director, Bruner Family Medicine Center, Denver, CO

Patient and family advisors at Ocean Park Health Center, San Francisco, CA

Patient and family advisors planned the "walk and talk series."

Ocean Park Health Center
San Francisco, CA

The Patient Advisory Council members have been enthusiastic, and interested in improving care of patients and outreaching to the community.

Each time I attend their meetings, their energy and passion revitalizes me and helps me to remember the reasons for which we are all here: to serve our patients.

Lisa Golden, MD, Medical Director
Ocean Park Health Center,
San Francisco, CA

2015

TCPi Transforming Clinical Practices Initiative

- A four-year CMS initiative for the U.S., designed to help clinicians achieve large-scale health transformation (2015 – 2019).
- Support more than 140,000 clinician practices in sharing, adapting, and further developing comprehensive quality improvement strategies.
- One of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation.

https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

TCPi Transforming Clinical Practice Initiative

TCPI Change Package: Transforming Clinical Practice

Driver Diagram

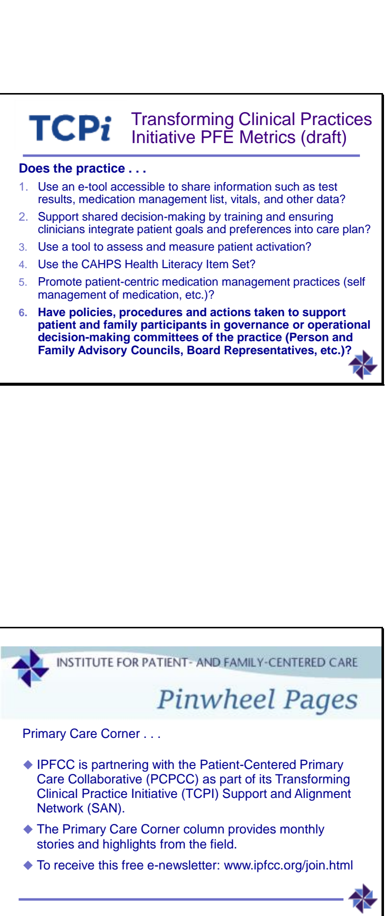
The TCPI Change Package, which is built on the driver diagram model below, describes the changes needed to transform clinical practice and meet TCPI goals. The driver diagram shows the relationships among goals, the primary drivers that contribute to achieving those goals, and the subsequent factors that are necessary to achieve the primary drivers. The change package is a compilation of the interventions developed and tested by others.

TCPI AIMs/Goals

(1) Support more than 140,000 clinicians in their practice transformation work.
(2) Build the evidence based on practice transformation so that effective solutions can be scaled.
(3) Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients.
(4) Reduce unnecessary hospitalizations for 5 million patients.
(5) Sustain efficient care delivery by reducing unnecessary testing and procedures.
(6) Generate $1 to $4 billion in savings to the federal government and commercial payers.
(7) Transition 75% of practices completing the program to participate in Alternative Payment Models

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

www.nrhi.org/uploads/tcpi-change-package_color_march-16_v20.pdf



TCPi Transforming Clinical Practices Initiative PFE Metrics (draft)

Does the practice . . .

1. Use an e-tool accessible to share information such as test results, medication management list, vitals, and other data?
2. Support shared decision-making by training and ensuring clinicians integrate patient goals and preferences into care plan?
3. Use a tool to assess and measure patient activation?
4. Use the CAHPS Health Literacy Item Set?
5. Promote patient-centric medication management practices (self management of medication, etc.)?
6. **Have policies, procedures and actions taken to support patient and family participants in governance or operational decision-making committees of the practice (Person and Family Advisory Councils, Board Representatives, etc.)?**

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

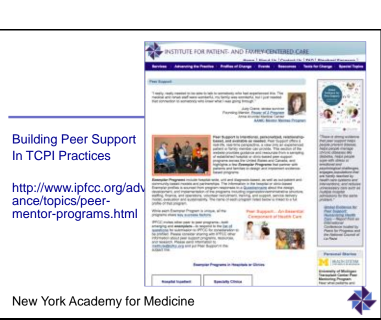
Pinwheel Pages

Primary Care Corner . . .

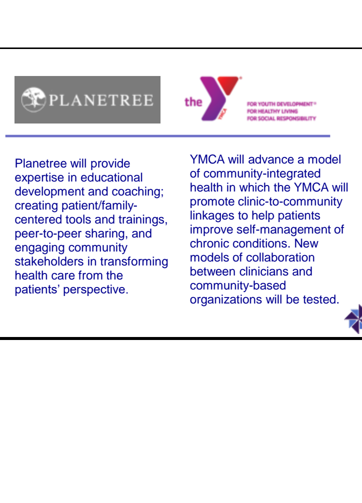
- IPFCC is partnering with the Patient-Centered Primary Care Collaborative (PCPCC) as part of its Transforming Clinical Practice Initiative (TCPI) Support and Alignment Network (SAN).
- The Primary Care Corner column provides monthly stories and highlights from the field.
- To receive this free e-newsletter: www.ipfcc.org/join.html

Building Peer Support In TCPI Practices

http://www.ipfcc.org/advance/topics/peer-mentor-programs.html



New York Academy for Medicine



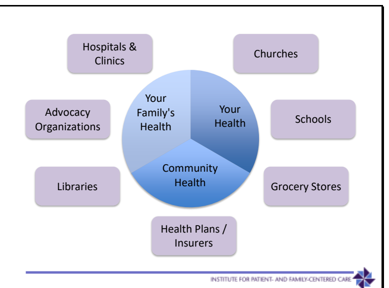
In Conclusion . . .

"Our patients and their families are an abundant source of wisdom as we navigate the stormy seas of healthcare delivery.

To go it alone without their partnership is foolish and unwise. With patients as equal partners in this journey, our work together is more fulfilling, more meaningful, and more likely to help them reach their health goals."

Joseph Bianco, MD, FAAFP, Director of Primary Care for Essentia, Ely, MN

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE



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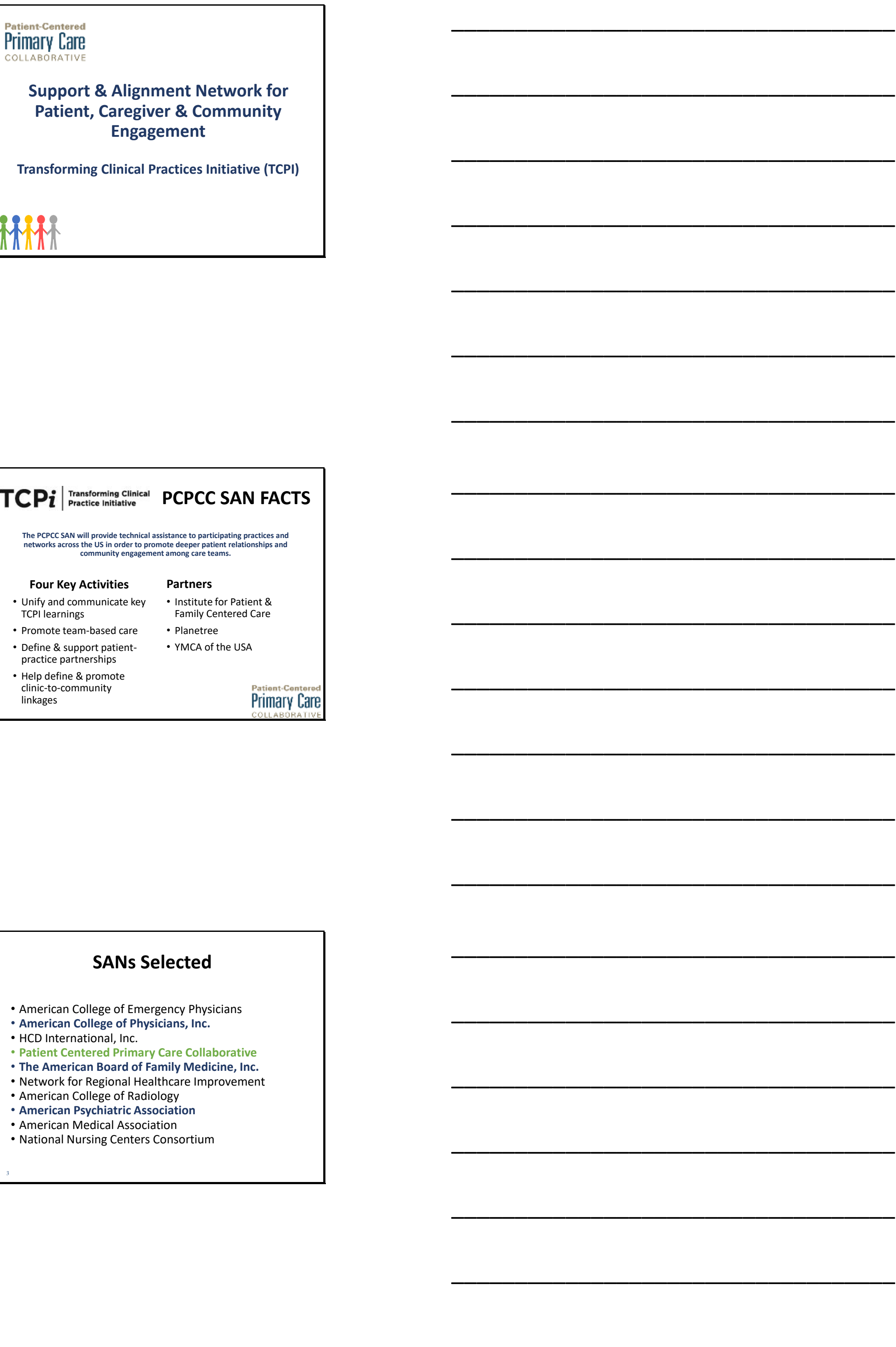
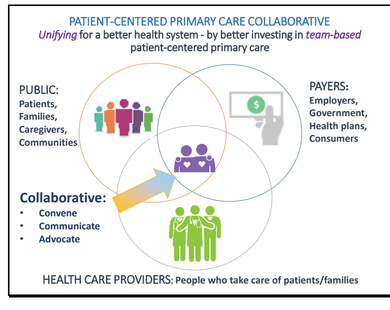
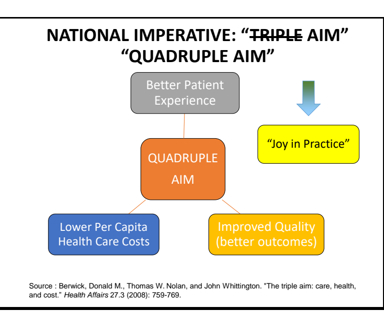
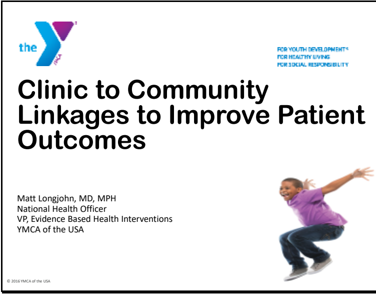
Role of PCPCC SAN Grant in Helping Achieve TCPI Goals




PATIENT-CENTERED PRIMARY CARE COLLABORATIVE
Unifying for a better health system - by better investing in team-based patient-centered primary care
PUBLIC:
Patients,
Families,
Caregivers,
Communities
PAYERS:
Employers,
Government,
Health plans,
Consumers
Collaborative:
Convene
Communicate
Advocate
HEALTH CARE PROVIDERS: People who take care of patients/families


NATIONAL IMPERATIVE: "TRIPLE AIM"
"QUADRUPLE AIM"
Better Patient Experience
"Joy in Practice"
QUADRUPLE AIM
Lower Per Capita Health Care Costs
Improved Quality (better outcomes)
Source : Berwick, Donald M., Thomas W. Nolan, and John Whittington. "The triple aim: care, health, and cost." Health Affairs 27.3 (2008): 759-769.

PLANETREE
The Standard for Patient-Centered Excellence
formula for Success
PA
SE
LD
PI
17 Countries
Over 700 Organizations
started by
1 patient
in 1978
powered by
50,000
voices
over
9,000,000
lives impacted
Drives Quality
across the continuum
Accelerates STAFF and PATIENT
Satisfaction
Advocates for Change with
National Quality Forum (NQF)
Institute of Medicine (IOM)
World Health Organization (WHO)
Institute for Healthcare Improvement (IHI)



The Changing Health Care Landscape

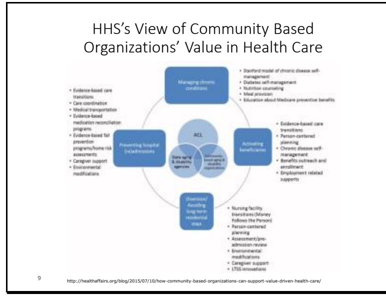
Past	Present	Future
Acute Health Care System	**Coordinated Seamless Health Care System**	**Community Integrated Health Care System**

Past – Acute Health Care System
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

Present – Coordinated Seamless Health Care System
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

Future – Community Integrated Health Care System
- High quality acute care
- Accountable care systems
- Shared financial risk
- **Case management and Preventive care systems**
- **Population-based quality and cost performance**
- **Population-based health outcomes**
- **Care System integration with community health resources**

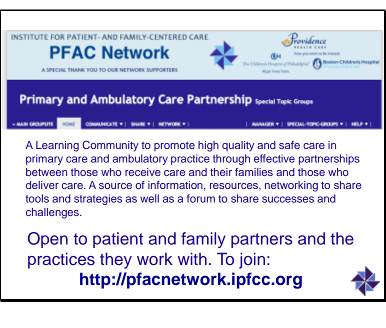
Source: *http://innovation.cms.gov/resources/State-Innovation-Models-Initiative-Overview-for-State-Officials.html*



www.ipfcc.org

IPFCC Training and Technical Assistance in the PCPCC SAN

- Support for Patient and Family Advisors
  - Learn about your role in quality improvement in primary or ambulatory care
  - Network with other advisors across North America
- Support for Health Care Practices
  - Webinars on important partnership topics
  - Peer Support technical assistance for development within the practice
- For All:
  - Coaching calls, technical assistance, and virtual support including Storytelling
  - IPFCC Seminar Scholarships



INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
PFAC Network
A SPECIAL THANK YOU TO OUR NETWORK SUPPORTERS
Providence
Boston Children's Hospital
Primary and Ambulatory Care Partnership Special Topic Groups
A Learning Community to promote high quality and safe care in primary care and ambulatory practice through effective partnerships between those who receive care and their families and those who deliver care. A source of information, resources, networking to share tools and strategies as well as a forum to share successes and challenges.
Open to patient and family partners and the practices they work with. To join:
http://pfacnetwork.ipfcc.org

Peer Support
http://www.ipfcc.org/advance/topics/peer-mentor-programs.html
INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
Services
Advancing the Practice
Profiles of Change
Events
Resources
Tools for Change
Special Topics
Peer Support
Peer Support... An Essential Component of Health Care

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Developing Patient and Family Partnerships in Practice Transformation

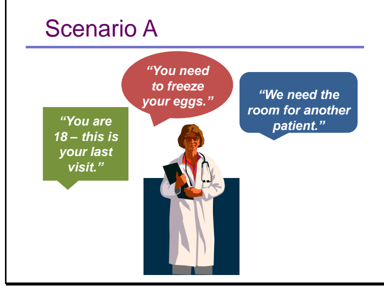
Mary Minniti, BS, CPHQ
Senior Policy and Program Specialist
Kelly Parent, BS
Program Specialist for Patient and Family Partnerships

Objectives

- Discuss how to transform primary and ambulatory care practices into high quality and satisfying experiences through partnership with patients and families at the point-of-care and at beyond.
- Explore the roles that patient and family advisors can play to improve quality and safety.
- Share best practices demonstrated across primary and ambulatory care programs, their success and challenges.

"People will forget what you said. People will forget what you did. But people will never forget how you made them feel."

~Maya Angelou

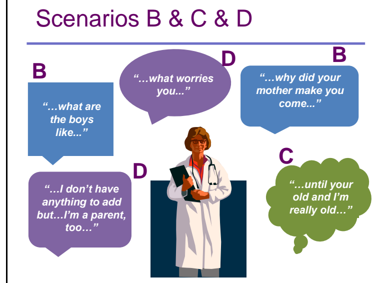


Outcomes of Clinic Visit

Young Adult Patient
- Confused
- Humiliated
- Unimportant
- Closed-mouthed
- "I am done…"

Mom
- Disrespected
- Angry
- Minimized
- Failure
- "We are done…"

"Doctor was only in the room for a couple of minutes."



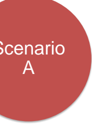
Outcomes of Clinic Visits

Patient
- Felt like a kid not a disease
- Felt reassured
- Felt listened to
- Felt the compassion
- "I liked him/her…"

Mom
- Validated
- Respected
- Hope
- "A good mom"
- "I would recommend…"

"Doctors took all of the time that they needed to take with us."

In all reality… *TIME* does not have to be limiting



What is Patient- and Family Centered Care?

Partnerships based on
Respect & Dignity, Information Sharing,
Participation, and Collaboration

Patient- and family-centered care is working "with" patients and families, rather than just doing "to" or "for" them.

Patient- and family-centered care provides the framework and strategies to **transform organizational culture** and improve the experience of care, and enhance quality, safety, and efficiency.

Transforming Healthcare: A Safety Imperative

"We **envisage patients as essential and respected partners in their own care** and in the design and execution of all aspects of healthcare. In this new world of healthcare:

Organizations publicly and consistently affirm the centrality of patient-and family-centered care. They seek out patients, listen to them, hear their stories, are open and honest with them, and take action with them.

. . . Continued

Leape, L., Berwick, D., Clancy, C., & Conway, J., et al. (2009). Transforming healthcare: A safety imperative, *BMJ's Quality and Safety in Health Care.* Available at: http://qshc.bmj.com/content/18/6/424.full

Transforming Healthcare: A Safety Imperative (cont’d)

The family is respected as part of the care team—never visitors—in every area of the hospital, including the emergency department and the intensive care unit.

Patients share fully in decision-making and are guided on how to self-manage, partner with their clinicians and develop their own care plans. They are spoken to in a way they can understand and are empowered to be in control of their care.”

‘Blockbuster Drug’ *Patient Engagement*

“Engagement, broadly defined, is an **active partnership** among individuals, families, health care clinicians, staff, and leaders to improve the health of individuals and communities, and to improve the delivery of health care.”

Health Affairs, 32(2) 2013

Collaborative Patient and Family Engagement

Collaborative patient and family engagement is a **strategy for building a patient- and family-centered system of care**. It is a priority consideration and essential to health reform at four levels:

- At the clinical encounter—patient and family engagement in direct care, care planning, and decision-making.
- At the practice or organizational level—patient and family engagement in quality improvement and health care redesign.
- At the community level—bringing together community resources with health care organizations, patients, and families.
- At policy levels—locally, regionally, and nationally.

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

16

Change The Assumptions

I WANT YOU

Assume ***patients*** are the ***experts*** on their own experience and that they have information ***you need to hear and act on.***

Know that **families** are **primary partners** in a patient's experience and health.

Patient & Family Perceptions and Expectations

What do Patients and Families Expect…

- To receive high-quality, safe care
- To be present
- To be listened to, taken seriously, and respected as a care partner
- To have full and timely access to medical information
- To have coordination among all members of health care team across all settings
- To always be told the truth with full explanations, transparency and apology
- To be supported emotionally as well as physically

Support-Comfort-Information-Proximity-Assurance

Learning Through Surveys
e-Advisor Survey, 2014

What do families want at clinic appointment?

- **Ample time spent with physician**
- Short wait to get to exam room.
- Short wait to see physician.
- Pleasant and helpful greeting.

"I did appreciate the note on the board stating how far behind the doctor was running. It was a long wait but we appreciated having the heads up."

Learning Through Surveys
e-Advisor Survey, 2010

What makes an unpleasant clinic appointment?

- **Long waits (over an hour)**
- Not being heard
- Lack of follow through
- Repeating story multiple times
- Needing to go to multiple locations to see different people when scheduling surgery
- Unpleasant or rude greeting
- Leaving the clinic with no plan
- **Driving a distance only to have minimal time with the physician**

Learning Through Surveys
e-Advisor Survey, 2010

What Makes a Positive Check-in Experience?

- Responsive staff who are friendly, pleasant, and sincere (appropriate smile and eye contact)
- Prepared greeter staff who know who you are and why you are there.
- Staff that do not make us feel that you are inconvenienced by us.
- Staff who listen to our concerns.
- For pediatric patients, staff who talk to our child and/or are ready with distraction activities.

"First impressions mean a lot."

Partnering with Patients and Families at the Point-of-Care

Seeing the Person Behind the Patient and the Disease

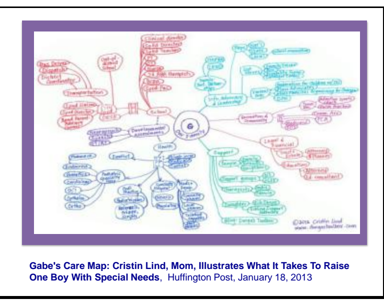
- Who is this person?
- How can I connect with this patient as a person?
- Who are the important people in the person's life?
- How does this person fit into her family, community, world?
- What is important to this person and her family?

Challenges of Patients and Families

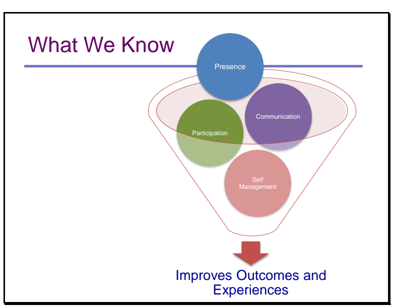
- Cognitive
- Emotional
- Social
- Financial
- Spiritual

The Impact of Illness and Injury on Social Identity

- Illness or injury may mean time away from our loved ones.
- Illness or injury may mean that we need to give up activities that we love.
- Illness and injury may mean that we have less in common with old friends.
- Illness or injury may mean that we will connect with people that we may not previously have thought possible.
- Illness or injury may mean that we will not be home for holidays.

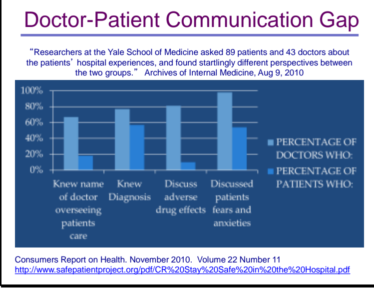


Gabe's Care Map: Cristin Lind, Mom, Illustrates What It Takes To Raise One Boy With Special Needs, Huffington Post, January 18, 2013



Doctor-Patient Communication Gap

"Researchers at the Yale School of Medicine asked 89 patients and 43 doctors about the patients' hospital experiences, and found startlingly different perspectives between the two groups." Archives of Internal Medicine, Aug 9, 2010



Consumers Report on Health. November 2010. Volume 22 Number 11
http://www.safepatientproject.org/pdf/CR%20Stay%20Safe%20in%20the%20Hospital.pdf

Presence and Participation

An engaged and informed family leads to better health care outcomes

- Family observations can improve clinical decision-making
- Families can be allies in preventing medication errors and promoting patient safety

Continuing presence and familiar roles enhance family well-being, confidence, and competence

- Breeds trust in the healthcare system
- Increases knowledge of patient's true condition
- High acuity and complex care education takes time

Provider-Family Partnerships Improve Care

Families who reported never or only sometimes feeling like a partner were

- ~10 times more likely to be dissatisfied with services
- ~4 times more likely not to get needed specialty services
- ~2 to 3 times more likely to have unmet needs for either child or family

Denboba, D. et al. Achieving Family and Provider Partnerships for Children with Special Health Care Needs. Pediatrics. 2006; 118(4): 1607-1615.

Words of Engagement

Encourage Patient to Speak Up

- "Tell me more. This is really helpful."
- "What do YOU think caused the problem?"
- "What are YOUR thoughts about how we should address this?"
- "What's worrying you most at this point?"

Invite Family to Share (with permission)

- Would you mind telling me a little about your father? It will help me provide better care to get a sense of him as a person."
- "Please tell me about your mother's routine, so we can help her prepare to go home."

Assessing Education: Self Management

Many studies have shown that the patients "with the skills, ability, and willingness to manage their own health and health care—experience better health outcomes at lower cost."

- How confident do I feel to manage my health?
- What knowledge do I have about my conditions?
- What skills to I have to do that which is necessary to maintain and improve my health?

Health Policy Brief, Health Affairs, February 14, 2013
For information about the measure: www.insigniahealth.com
Judith Hibbard, Patient Activation Measure, University of Oregon

Peer Support – Lucile Packard Children's Hospital at Stanford

- Making the most of a clinic visit
- How to schedule multiple appointments
- How to manage medications
- Partnering with healthcare providers
- Coordinating care between Packard and community services
- How to parent in the hospital
- Who's who on your health
- Learning about your child's health condition
- Effective ways to communicate with care providers
- Understanding legal rights
- Working with the schools

Compliments of Karen Wayman, PhD

Self Management

Ryhov Hospital – provided training for patients interested in managing their own dialysis.

Result: 52% of renal patients on self-dialysis had fewer side effects and lower infection rates.

UMHS

Orthopedic Surgery: hip replacement surgery – support person training. Result: 80% reduction in falls.

Cystectomy: provided patient journals post-discharge. Patients input led to answering why renal issues were occurring post-op.

Howard University Hospital – provided diabetes patients with access to personal health records to assist them in monitoring clinical indicators pertinent to diabetic health.

Result – Hgb A1c levels fell by 13% for patients participating in the program compared to an increase in levels for nonparticipating patients.

UMHS

C.S. Mott Children's Hospital: Pediatric Urology: Perioperative Process Improvement Project– hypospadias catheter and dressing care instruction while the child is in surgery.

Special Needs

"Anticipated" Discharge Fears	No. of #1 Rankings	Ranking in Top 3	Ranking in Bottom 3
Death of Loved One	11	16	9
Competence of Home Care Providers	6	17	10
Care Coordination	5	13	3
Infection/Clean Technique	4	24	3
Lack Knowledge of Needs	4	10	12
Ability to Reach Medical Providers	2	11	5
Knowing When to Return to Hospital	2	12	5
Finding a "New" Normal	1	1	18
Paying for Care	0	2	16
Loneliness/Isolation	0	0	26

After Discharge…

- What came as a surprise?
  - Exhaustion
  - Balancing life and finding normal
  - Loneliness, isolation and burden of responsibility
  - Expectation that I should be an expert
  - Expenses
- What was your biggest need?
  - Respite, rest
  - Communication and care coordination
  - Confirmation that I was doing things correctly
- What advice do you have?
  - Contact information – who to call and when
  - Supplies available when needed
  - Medication schedules and medical history
  - Practice before discharge – written, hands-on demonstrations, and video
  - Plan for discharge early in admission with home visits for discharge planning
  - Listen, answer questions, acknowledge fears
  - Don't rush the process

"Breaking bad news is actually a golden opportunity to deepen the patient-doctor relationship…For a doctor to be willing to be emotionally available is a tremendous gift for any patient."

Nila Webster, a stage four lung cancer patient

"Doctors are trained first to diagnose, treat and fix — and second, to comfort, palliate and soothe. The result is a slow loss of vision, an inability to see who and what people are outside the patient we see in the hospital……To better serve patients, we need to see not only who they are, but also who they were, and ultimately, who they hope to become even at the end of life."

Dhruv Khullar, MD, MPP, Massachusetts General Hospital and Harvard Medical School

As Bad as or Worse than Death…

Rubin, Emily B, MD, et al. States worse than death among hospitalized patients with serious illnesses. JAMA Intern Med. Published online August 01, 2016.

- Bowel and bladder incontinence, cited by about 70%.
- Reliance on a breathing machine, cited by about 70%.
- Inability to get out of bed, cited by about 70%..
- Being confused all the time, cited by about 60%.
- Reliance on a feeding tube, cited by about 55 percent of respondents.
- Needing around-the-clock care, cited by more than 50%.

Of Note:
- Patients may underestimate their abilities to adapt to certain healthcare states.
- The survey also found that a vast majority of respondents said that needing to be at home all day, being in moderate pain all the time, or needing to be in a wheelchair would not be preferable to death.

Remember the Caregiver

- Heroism
- Overwhelmed – emotional and financial
- Exhaustion – physical, mental and emotional
- Ambivalence
- New Normal

In Summary

How Patient- and Family-Centered is Your Clinic?

- Does your patient education vision, mission, and philosophy reflect the principles of patient- and family-centered care?
- DO you inform patients and families how you expect them to engage in their care? Do you provide checklists?
- Are there systems in place to ensure that patients and families have access to complete, unbiased, and useful information?
- Do educational materials convey respect for families and their pivotal role in promoting health and well-being?
- Do you ensure communication that is understood by those with limited English proficiency, low health literacy and those who are hard of hearing?
- Do patients and families serve as advisors on committees and work groups involved in education efforts?

Patients and Families are Essential Partners for Innovation, Quality Improvement, and Health Care Redesign

A Key Lever for Leaders . . . Putting Patients and Families on the Improvement Team

In a growing number of instances where truly stunning levels of improvement have been achieved...

Leaders of these organizations often cite—putting patients and families in a position of real power and influence, using their wisdom and experience to redesign and improve care systems—as being the single most powerful transformational change in their history.

Reinertsen, J. L., Bisagnano, M., & Pugh, M. D. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care*, 2nd Edition, IHI Innovation Series, 2008. Available at www.ihi.org.

Patients and Family Advisors

Any role in which those who receive care work together with health care professionals to improve care for everyone. Advisors share insights and perspectives about the experience of care and offer suggestions for change and improvement.

Why Involve Patients and Families as Advisors?

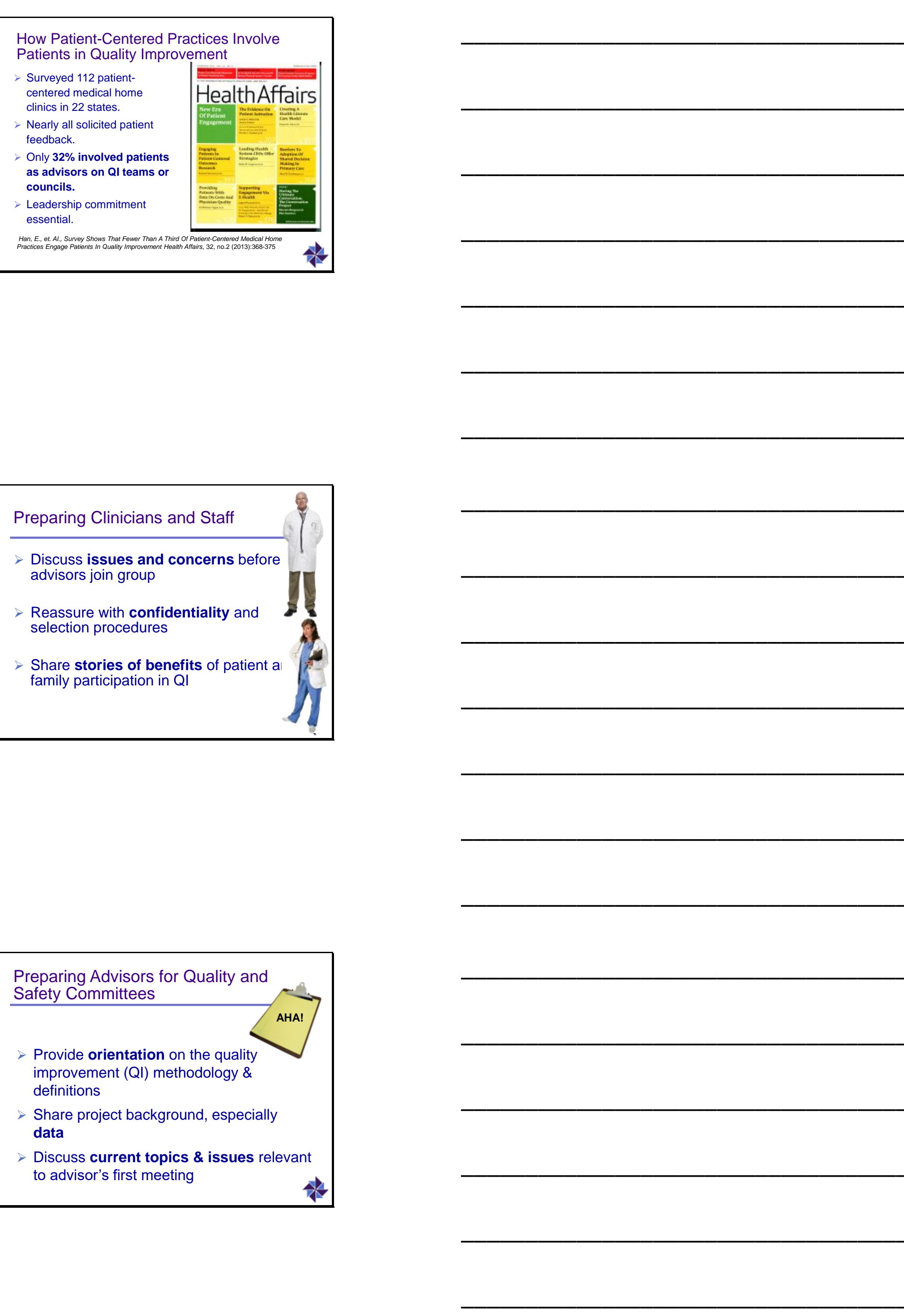
- Bring important perspectives.
- Teach how systems really work.
- Keep staff grounded in reality.
- Provide timely feedback and ideas.
- Inspire and energize staff.
- Lessen the burden on staff to fix the problems… staff do not have to have all the answers.
- Bring connections with the community.
- Offer an opportunity to "give back."

Qualities and Skills of Successful Patient and Family Advisors

- The ability to share personal experiences in ways that others can learn from them.
- The ability to see the bigger picture.
- Interested in more than one agenda issue.
- The ability to listen and hear other points of view.
- The ability to connect with people.
- A sense of humor.
- Representative of the patients and families served by the hospital and clinics.

Useful Framework for Participation

Depth of Engagement	Patients and Family Role	Things to Consider
Ad Hoc Input	Survey or Focus Group Participants	Ensure diversity and representation, validity
Structured Consultation	Council or Advisors-provides QI input	Early consult supports partnership model
Influence	Occasional Review/Consultants to project	Allows flexible ways to participate; requires background/orient.
Negotiation	Member of QI Group	Training in QI approach
Delegation	Co-Chair of QI Group	High level of expertise or skill
Advisor Control	Implementer or peer support role	Strong training component, mentoring and compensation


How Patient-Centered Practices Involve Patients in Quality Improvement
Surveyed 112 patient-centered medical home clinics in 22 states.
Nearly all solicited patient feedback.
Only 32% involved patients as advisors on QI teams or councils.
Leadership commitment essential.
Health Affairs
New Era Of Patient Engagement
Han, E., et. Al., Survey Shows That Fewer Than A Third Of Patient-Centered Medical Home Practices Engage Patients In Quality Improvement Health Affairs, 32, no.2 (2013):368-375
Preparing Clinicians and Staff
Discuss issues and concerns before advisors join group
Reassure with confidentiality and selection procedures
Share stories of benefits of patient a
family participation in QI
Preparing Advisors for Quality and Safety Committees
AHA!
Provide orientation on the quality improvement (QI) methodology & definitions
Share project background, especially data
Discuss current topics & issues relevant to advisor's first meeting

Preparing Advisors for Quality and Safety Committees (cont.)

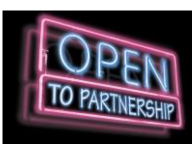
- Arrange a **pre-meeting** with the Chair of the committee
- Identify a **mentor** for the advisor who also serves on committee
- Share **tips and tools** developed by experienced advisors
- Provide opportunity to **debrief** first 3 meetings

Preparing Clinicians and Staff

- Provide a **bio sketch of advisor** and a picture
- Foster a **"listen first"** approach
- Encourage an **acronym-free zone**
- Place advisors **strategically close** to chair or group facilitator

Fostering a Successful Beginning: Tips for Staff

- Explain how staff should be involved.
  - The importance of listening.
  - Effective approaches to meeting facilitation.
  - Act on advisors observations and recommendations when appropriate and provide information when not implemented.
- Be open to questions and challenges.
- Try not to be defensive.
  - Respond/explain when questions are asked.



Exemplars Across the Continuum

PeaceHealth

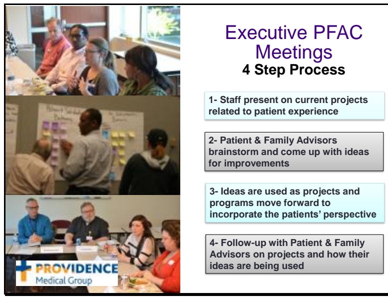
PATIENT INTIATED SAFETY PROJECT

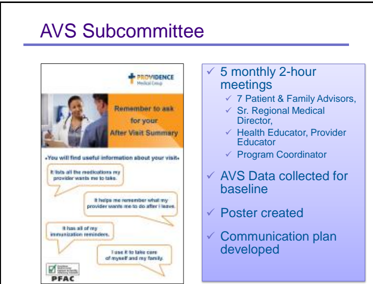
http://www.peacehealth.org/phmg/eugene-springfield/eugene-springfield-locations/patient-services/for-new-patients/Pages/your-medications.aspx

Offer Variety in the Complexity of Projects

Easy	Moderate	Difficult
Providing input on wayfinding to practices, offices, exam rooms	Mentoring other advisors and recruiting for diversity within council	Participated in content and filming of a new patient experience model of care
Review of health information and media materials	Participating in organizational learning opportunities	Designed and Produced DVD on patient safety that was used as a model of the impact of advisors
Artwork selection for lobbies and waiting rooms	Establishing PAC award to providers/departments who embrace PFCC Principles	Patient Centered Medical Home transformation
Providing feedback on Patient Portals	Participating on New Nurse Panels on chronic illness from a patient's point of view	Service for Excellence Plan - Agenda Setting - piloted with new Medical Home in Adult and Family Medicine
Participating in Employee and Provider Appreciation Days	Sharing personal stories on experience of care	Collaborated in designing course content for front office staff training
Feedback on surveys	Serving on organizational committees - Clinical Councils, Quality Councils, Patient Safety Councils	Participate in interview panels for new Adult and Family Medicine Chief (key physician leader)
Promote visibility of PAC partnerships by random site visits to thank staff	Collaborated on Welcome Brochures	Help mentor and orient new physicians and managers to the practice

PeaceHealth Medical Group

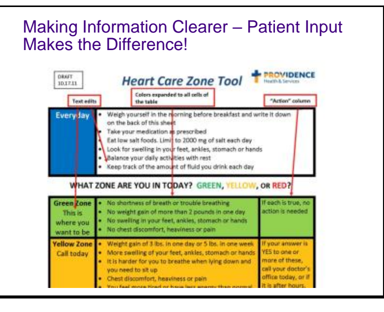


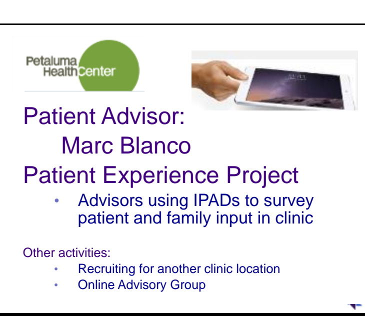


As a Result…

Patient & Family Advisors presented to leadership, all clinic managers and medical directors, 3 months later the **increase in the issue rate was 29.29%**

"**This is remarkable work! It shows the power of engaging our patients in quality improvement work as partners.**" - Dr. Ben LeBlanc CMO

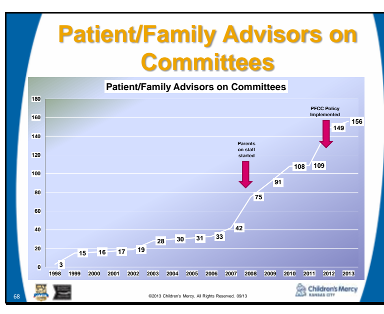

Making Information Clearer – Patient Input Makes the Difference!
DRAFT 10.17.11
Heart Care Zone Tool
PROVIDENCE Health & Services
Text edits
Colors expanded to all cells of the table
"Action" column
Everyday
• Weigh yourself in the morning before breakfast and write it down on the back of this sheet
• Take your medication as prescribed
• Eat low salt foods. Limit to 2000 mg of salt each day
• Look for swelling in your feet, ankles, stomach or hands
• Balance your daily activities with rest
• Keep track of the amount of fluid you drink each day
WHAT ZONE ARE YOU IN TODAY? GREEN, YELLOW, OR RED?
Green Zone This is where you want to be
• No shortness of breath or trouble breathing
• No weight gain of more than 2 pounds in one day
• No swelling in your feet, ankles, stomach or hands
• No chest discomfort, heaviness or pain
If each is true, no action is needed
Yellow Zone Call today
• Weight gain of 3 lbs. in one day or 5 lbs. in one week
• More swelling of your feet, ankles, stomach or hands
• It is harder for you to breathe when lying down and you need to sit up
• Chest discomfort, heaviness or pain
If your answer is YES to one or more of these, call your doctor's office today, or if it is after hours,

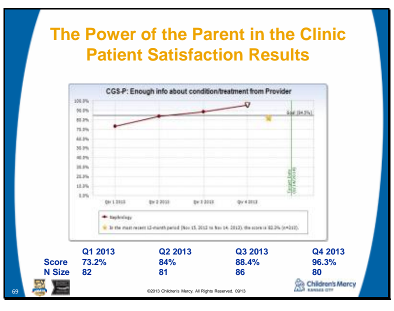

Petaluma Health Center
Patient Advisor:
Marc Blanco
Patient Experience Project
• Advisors using IPADs to survey patient and family input in clinic
Other activities:
• Recruiting for another clinic location
• Online Advisory Group

Silver Aven
SAFHC
Silver Avenue Family Health Center
Silver Exchange
(Advisory Council)
Recent projects: revision of patient letters, waiting room improvements, logo contest
Evin, his family and staff from the Silver Ave Clinic

Collaboration Beyond Advisory Councils

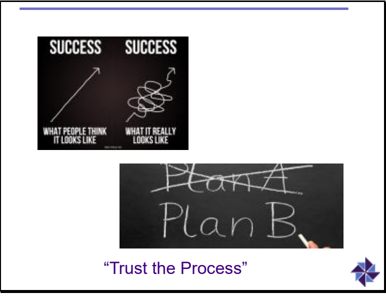
- Invite patients with a chronic condition to participate in a clinic team working on improving educational materials or programs to that population of patients.
- Identify patients new to the clinic to participate in a "photo walk-about" to take pictures of ways the clinic is welcoming and places where the messages could be more positive or where way-finding is confusing.
- Ask patients and family what is one change we could make that would improve your experience? Collect the responses and form a clinic team with advisors to follow-up on suggestions.





Benefits of Advisors on QI Teams

- Health care professionals & staff make fewer assumptions about what patients or families "want".
- Advisors "see things differently" and ask "why do you do it this way?"
- Advisors challenge what's possible.
- Advisors offer hope, assistance, and support.

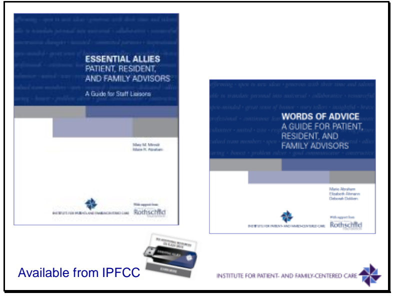


"Trust the Process"

Discussion

Learning from others

- How have you partnered with Patients and Families or how would you like to partner with them?
- Patient and Family Partners: What has been your experience or what are your hopes for working with your health care organizations?
- What are the areas for which you could use advice on how to increase engagement in your clinic?
- Share your best practices.



Questions

mminniti@ipfcc.org
kparent@ipfcc.org

Mechanisms for Establishing Successful Partnerships between Practices and Community-Based Organizations; YMCA's DPP and Other Examples

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OBJECTIVES

1. PROVIDE A PERSPECTIVE ON THE TRENDS IN POPULATION HEALTH, AND THE ROLE OF THE Y IN HEALTH CARE TRANSFORMATION
2. DISCUSS Y-USA'S INFRASTRUCTURE FOR SUPPORTING CHRONIC DISEASE PREVENTION PROGRAMS.
3. DISCUSS THE EMERGING ROLE OF CBOS IN SUPPORTING CLINICAL PRACTICE CLINICAL IMPROVEMENT ACTIVITIES
4. ANSWER QUESTIONS

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TRENDS IN POPULATION HEALTH: THE Y'S CHANGING ROLE

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IMPACT OF HEALTH REFORM

- Health reform efforts are shifting the financial incentives from fee-for-service to payment for health outcomes
  - Value-Based Payment Contracting
  - Alternative Payment Models
- Success in a value-based payment contract requires a progressive population health strategy
- Best practice models of population health align health systems with community-based organizations to synergize efforts to address the health of targeted health risks in the community

COMMUNITY INTEGRATED HEALTH

- Comprehensive population health strategy that integrates health systems, providers, and community-based health promotion programs to address the breadth of health issues facing a population
- Elements of success:
  - Treatment strategies that fully implement primary, secondary, and tertiary prevention strategies
  - Clinical pathways to support placing members in appropriate treatment tracts - based on risk stratification
  - Deployment of evidence-based programs in community settings

THE Y'S PORTFOLIO OF EVIDENCE-BASED (RCT PROVEN) PROGRAMS

DISCOVERY: Efficacy, Validation
DEVELOPMENT: Translation, Scaling
DISSEMINATION: Dissemination

- YMCA's Diabetes Prevention Program
- Enhance Fitness (Arthritis Self-Management)
- LIVESTRONG at the YMCA (Cancer Survivorship)
- Moving For Better Balance (Falls Prevention)
- Blood Pressure Self-Monitoring
- Childhood Obesity Intervention
- Brain Health
- Parkinson's
- Tobacco Cessation

Building the pool of the 21st century

THE ROLE OF THE Y IN ALTERNATIVE PAYMENT MODELS (APMS)

CLINICAL PATHWAYS SUPPORTING EVIDENCE-BASED PROGRAMS VIA ALTERNATIVE PAYMENT MODELS

- Clinical Pathways that fully implement primary, secondary, and tertiary prevention are essential to success in APMs
- Prevention efforts in community-based settings have increased adherence with sustained disease self-management impacts and are essential to a comprehensive population health strategy
  - Medicare Shared Savings ACO
  - Bundled Payment
  - Oncology Care Model

Y EVIDENCE-BASED PROGRAMS SUPPORTING APMS

- Alternative Payment Models provide financial incentives to achieve cost savings and improve clinical outcomes
- The APM model provides the ability to risk stratify the target population using clinical indicators and Medicare claims data
- Targeted high-risk beneficiaries are referred to the appropriate primary or secondary prevention program
- YMCA evidence-based programs provide the capacity to implement preventive health strategies that are proven to drive improvement of clinical outcomes and reduction in overall healthcare expenditures

Y EVIDENCE-BASED PROGRAMS INTEGRATED WITH APMS

- Medicare Shared Savings Program
  - ACO risk stratification to determine populations at-risk for diabetes
  - Enrollment in a Y DPP Program
  - Achievement of cost savings and clinical outcome improvement in the targeted ACO population
- Cardiac Care / Cardiac Rehab Bundled Payment
  - Cardiac Rehab Shared Space
  - Blood Pressure Self-Monitoring Program

INTEGRATION WITH APMS (CONT.)

- Oncology Care Model
  - LIVE**STRONG**® at the YMCA
  - Improved incentives for improved outcomes for beneficiaries diagnosed with cancer
  - Support and Navigation activities
- Comprehensive Joint Replacement Bundled Payment
  - Moving For Better Balance Program – supporting knee replacement beneficiaries during days 61 – 90 of a bundled payment episode

SUPPORTING MACRA CLINICAL IMPROVEMENT ACTIVITY REQ.

MACRA – MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT

- Establishes a Merit Incentive Program
  - First Performance period begins January 1, 2017
- Provider Reimbursement will be adjusted based on a defined scoring methodology
- Links Provider Payment to Outcomes
- Requires clinical practices to engage in clinical improvement activities
- Practice Transformation efforts support successful participation in MIPS payment model

CLINICAL IMPROVEMENT ACTIVITIES (CIA)

- Practices will be graded based on their performance in each CIA:
  - Expanded Practice Access
  - Population Management
  - Care Coordination
  - Beneficiary Engagement
  - Patient Safety and Practice Assessment
  - Achieving Health Equity
  - Emergency Response and Preparedness
  - Integrated Behavioral and Mental Health

EXAMPLE CLINICAL INTEGRATION PATHWAY SUPPORTING MIPS

- Practice Identification of population that has risk factors for diabetes
- Clinical pathways and E.H.R decision support tools that support provider referral to YMCA evidence-based DPP
- YMCA receipt of referral from provider E.H.R using electronic referral to Y E.H.R (Athena Health)
- Clinical documentation of delivery of DPP services to referred consumer
- YMCA E.H.R used to document services with summary report submitted to the referring provider

PROVIDER INCENTIVES FOR CLINICAL INTEGRATION

- YMCA as preferred community provider of evidence-based programs throughout the broad spectrum of the population supports the achievement of the following clinical improvement activities
  - Population Health
  - Care Coordination
  - Health Equity

Y-USA'S MANAGEMENT SERVICES ORGANIZATION

THE LATEST INNOVATION…

Authorized plan for Y-USA to **assume functions of a Management Services Organization (MSO) -- providing administrative, business, and technology services** to local Ys to enable them to receive third party payment for the delivery of the YMCA's DPP and other chronic disease prevention programs.

Local Ys

- Program delivery
- Track participant outcomes in technology system
- Raise funds to assist with sustainability in absence of 3rd party payors.

Chronic Disease Prevention Program Team

- Train Ys to deliver DPP and other evidence-based programs
- Management and administration support
- Coordinate with existing TPA for technology support
- Provide reporting technical assistance to Ys for reporting to partners, CDC, etc.

+

New Additional Structure

Healthy Living Department MSO

Employs staffs for:

- Payor Engagement
- Contracting
- Account Management
- Marketing
- Provider engagement
- Technology support
- Compliance
- Reporting
- Finance

"Build"

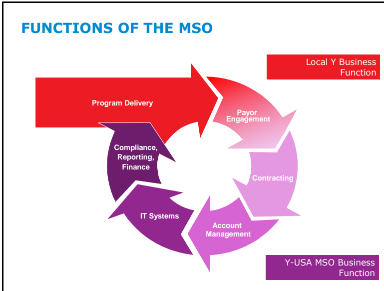
Contracts with vendors for:

- Technology platform
- Billing / revenue cycle management

athenahealth

"Buy"

FUNCTIONS OF THE MSO



EXAMPLE OF CLINICAL INTEGRATION

SHARED SPACE EXAMPLE

YMCA of Greater Charlotte:

- Existing shared space arrangement with a large health system serving their market
  - Health System provides direct medical services and preventive health services to community residents, inside the YMCA
- Relationship will expand to include a targeted focus of physician referrals to evidence-based prevention programs that are sustained through reimbursement contracts and inclusion in Alternative Payment Models
- Population Health Strategy includes providing targeted physician referrals to evidence—based interventions at the YMCA
- The YMCA will be a participant in the health system clinically integrated health network

QUESTIONS

the Y

THANK YOU

Creating Partnerships between Practices and Community-Based Organizations

OBJECTIVES

1. SHARE THE Y'S VISION FOR COMMUNITY INTEGRATED HEALTH
2. DISCUSS TECHNICAL ASSISTANCE PROVIDED TO LOCAL YS TO SUPPORT CLINICAL INTEGRATION
3. PROVIDE EXAMPLES OF HOW YS ARE INTEGRATING WITH HEALTH CARE PARTNERS
4. DESCRIBE HOW TO GET CONNECTED TO YOUR LOCAL Y AND ANSWER YOUR QUESTIONS

THE Y'S VISION FOR COMMUNITY INTEGRATED HEALTH

Y-USA'S STRATEGIC PLAN
IMPROVING THE NATION'S HEALTH AND WELL-BEING

Critical Social Issues Affecting Our Communities:

- High rates of chronic disease and obesity (child and adult)
- Needs associated with an aging population
- Health inequities among people of different backgrounds

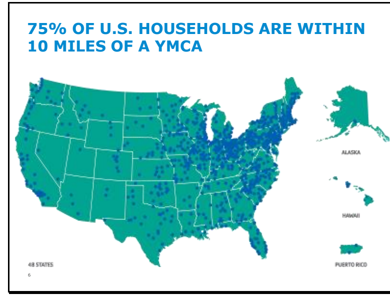
Our Shared Intent:

To improve lifestyle health and health outcomes in the U.S., the **Y will help lead the transformation of health and health care** from a system largely focused on treatment of illnesses to a collaborative community approach that elevates well-being, prevention and health maintenance.

Our Desired Outcomes:

- People achieve their personal health and well-being goals
- People reduce the common risk factors associated with chronic disease
- The healthy choice is the easy, accessible and affordable choice, especially in communities with the greatest health disparities
- Ys emphasize prevention for all people, whether they are healthy, at-risk or reclaiming their health
- Ys partner with the key stakeholders who influence health and well-being

4



Y-USA SUPPORT FOR CLINICAL INTEGRATION

TA PATHWAY TO SUPPORT CLINICAL INTEGRATION EFFORTS AT LOCAL YS

Information Gathering
- Y-USA Survey/Screener Tool
- Local Y Strategic Plan
- Partner Community Needs Assessment
- Alternative Payment Model opportunities

Information Sharing
- Conference call or face-to-face meeting

Strategy Development
- Local Y develops Value Proposition
- Y-USA helps local Y develop/define different pathways for partnership

Action
- Test and refine strategies

CLINICAL INTEGRATION IN ACTION

SHARED SPACE EXAMPLES

YMCA of Greater Grand Rapids (Grand Rapids, MI)

- Through partnership with a rehabilitation hospital, new Y built to meet Universal Design standards (intentional considerations to form and function to allow highest degree of accessibility).
- Able-bodied individuals and persons with disabilities are united under the pursuit of fully accessible sports, fitness, and general well-being.

YMCA of the Pikes Peak Region (Colorado Springs, CO)

- Partnership with local health system to build a new medical facility co-located with the Y
- Services include: primary care, urgent care, occupational medicine, imaging, physical therapy, pediatrics, women's services, behavioral health, & child watch

Greater Naples YMCA (Naples, FL)

- New Y facility built in partnership with multiple health care partners
- Services include: educational support for parents of children with special needs, early education programs, pediatrics, therapy (PT/OT/psychological), & child watch

REFERRAL DEVELOPMENT

THE Y'S PORTFOLIO OF EVIDENCE-BASED (RCT PROVEN) PROGRAMS

DISCOVERY: Efficacy, Validation
DEVELOPMENT: Translation, Scaling
DISSEMINATION: Dissemination

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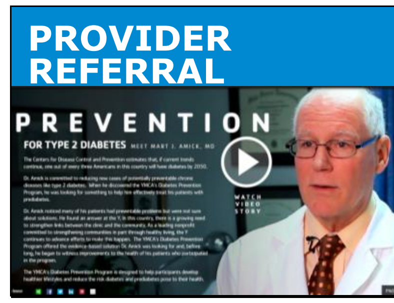
- Brain Health
- Parkinson's
- Tobacco Cessation

Building the pool of the 21st century



SIMPLIFYING THE REFERRAL PROCESS

Build it into the workflow

- Point of care
- Retrospective
- Electronic
- Feedback loop

Referral Sources

Source	Percent
Health care provider	29.60%
Marketing materials	29.40%
Staff member	10.50%
Family/friend or word of mouth	10.50%
Other	10.40%
Screening event or health fair	6.90%
Employer	2.70%

RECRUITMENT PARTNERS

It takes a village:

- Health care systems and physicians
- Senior centers
- Community organizations
- Health plans
- Faith-based organizations
- Media

17% yield from health care referrals

TYPES OF REFERRALS

- Indirect referral at point-of-care
  - Marketing collateral provided by Y at clinic
  - Up to patient to follow through with referral and contact local Y
- Direct referral at point-of-care
  - Typically facilitated by a health care provider champion
  - Clinician must obtain consent from patient to share info with local Y
  - Marketing collateral provided by Y - promoted/shared in clinic
  - Secure transmission of referral form for each patient

TYPES OF REFERRALS, CONTINUED

- Retrospective query
  - Often facilitated by non-clinical team members (e.g., care coordinator)
  - Targeted communication developed collaboratively (letter, call, etc.) between practice and local Y
  - Next step outlined in communication
  - Successful strategy during YMCA's Diabetes Prevention Program CMMI Project
- Track/evaluate referral process

LOOKING AHEAD: HOW THIS WILL BE ACHIEVED IN THE Y

Ys will use a single instance electronic medical record system provided by Athena Health to track participant outcomes and ease the burden of the referral on the health care provider.

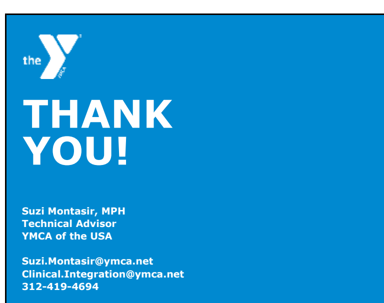
The system will also allow for a transfer of information back into the health care provider's record.

CONNECTING TO YOUR LOCAL Y

LOCATING YS PROVIDING EVIDENCE-BASED HEALTH INTERVENTIONS

- Systems being refined for some evidence-based health intervention public listings (e.g. Moving For Better Balance, Blood Pressure Self-Monitoring, & Healthy Weight and Your Child)
- However, you can find your local Y via http://www.ymca.net/find-your-y or identify contacts for the following programs, directly:
  - LIVE**STRONG**® at the YMCA (cancer survivorship): www.livestrong.org/ymca
  - YMCA's Diabetes Prevention Program: http://www.ymca.net/diabetes-prevention/locate-participating-y/
  - Enhance®Fitness (arthritis self-management & falls prevention): www.projectenhance.org

QUESTIONS?


the
THANK YOU!
Suzi Montasir, MPH
Technical Advisor
YMCA of the USA
Suzi.Montasir@ymca.net
Clinical.Integration@ymca.net
312-419-4694

Changing How We Do EVERYTHING! Moving from FOR Patients and Families to WITH Patients and Families

What if patients re-designed the healthcare system?

"As a patient I rebelled against being denied my humanity and that rebellion led to the beginnings of Planetree. We should all demand to be treated as competent adults, and take an active part in our healing. And we should insist on care settings meeting our human need for respect, control, warm and supportive care… A truly healing environment."

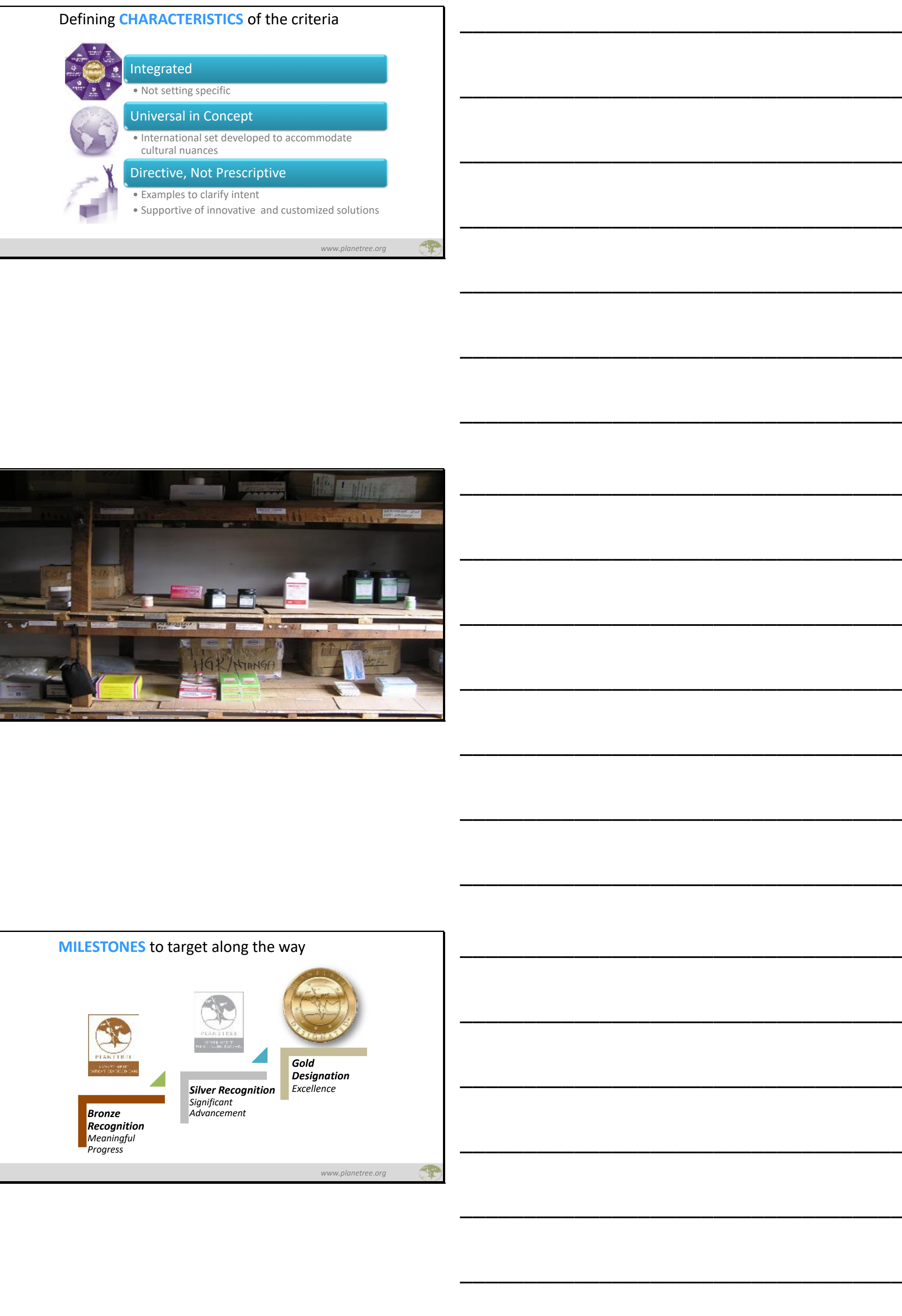
-Angelica Thieriot

www.planetree.org

IN HER OWN WORDS….

www.planetree.org

Planetree


Defining CHARACTERISTICS of the criteria
Integrated
• Not setting specific
Universal in Concept
• International set developed to accommodate cultural nuances
Directive, Not Prescriptive
• Examples to clarify intent
• Supportive of innovative and customized solutions
www.planetree.org
MILESTONES to target along the way
Bronze Recognition
Meaningful Progress
Silver Recognition
Significant Advancement
Gold Designation
Excellence
www.planetree.org

Raising the Bar with Planetree Designation

Patient and Family Engagement
I.E. Patient and Family Partnership Council
VIII.A. Accommodation of patient values and preferences in care planning
IV.A. Support for family presence during all aspects of visit

Staff training and support
II.A. Staff participation in experiential patient-centered immersion program
II.G. Care for the caregiver plan
II.J. Practice staff satisfaction survey

Promotion of authentic, trusting relationships
II.H. Patient-centeredness embedded into human resources systems
IX.B. Care provided with gentleness

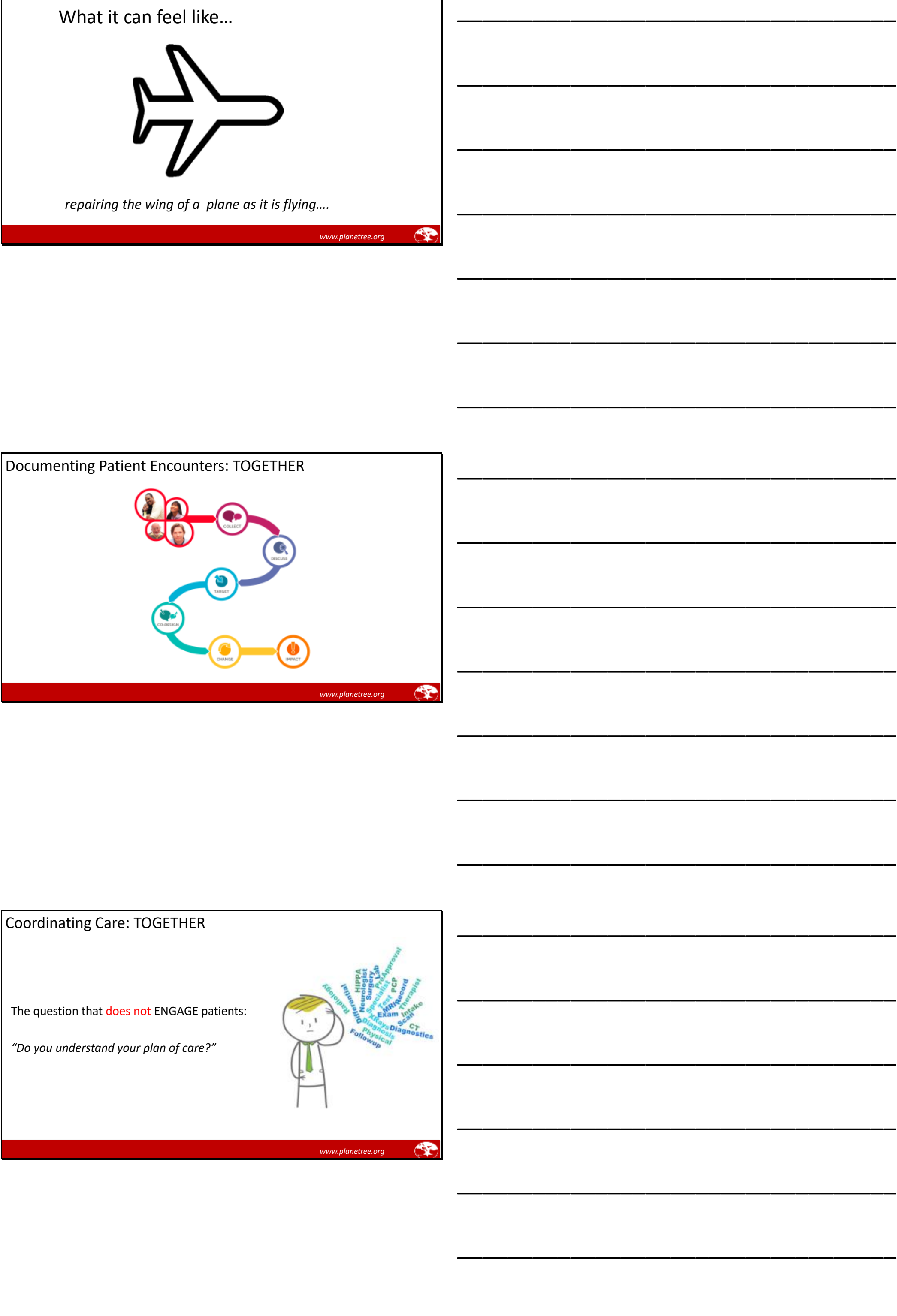
Patient co-design
VI.A. Users of space involved in office and clinical design efforts

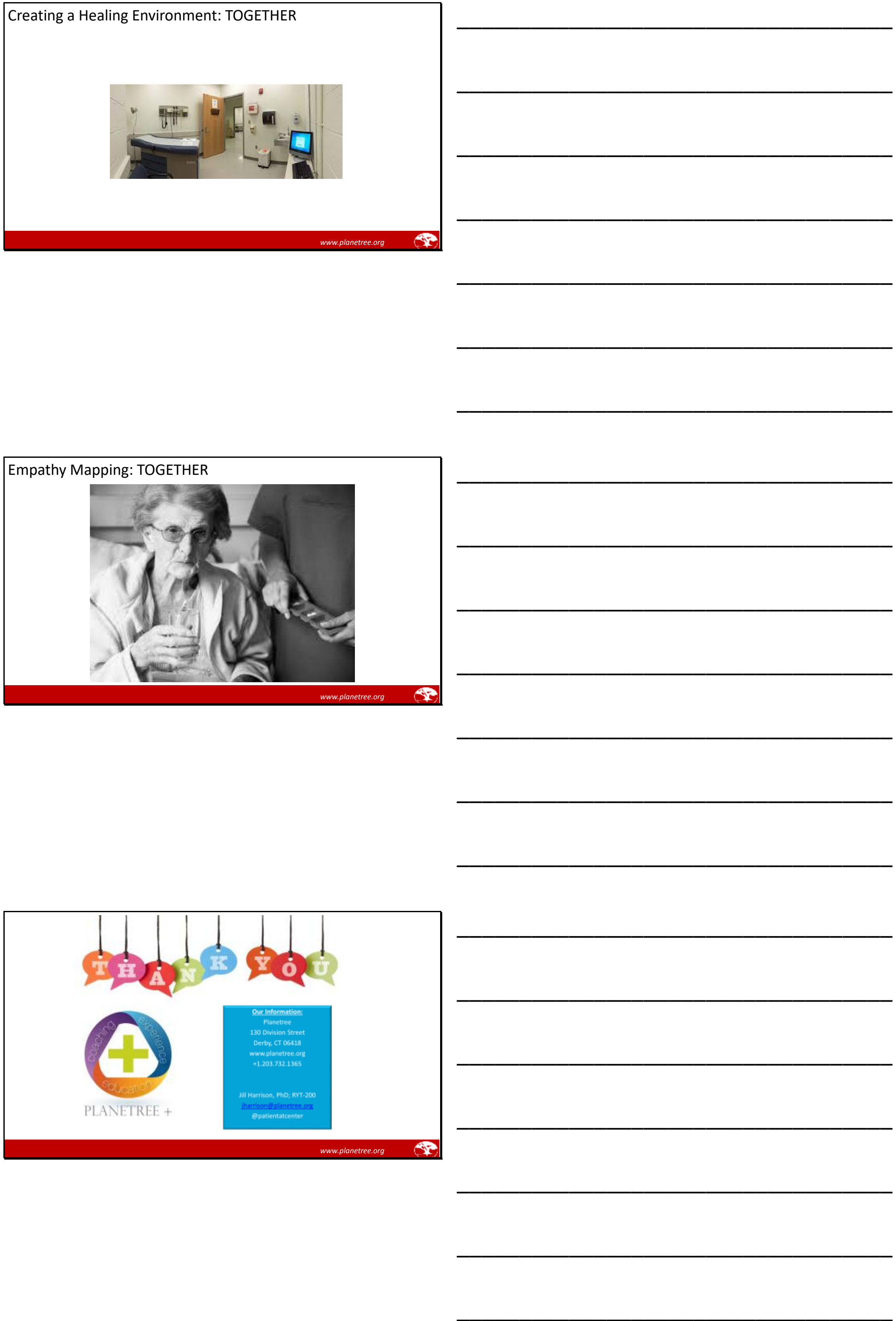
Healing Environment
VI.F. The environment accommodates privacy needs and provides for patient dignity and modesty.

"The care of a disease may be entirely impersonal; the care of the patient must be completely personal. The clinical picture is not just a photograph of a person in bed; it is an impressionistic painting of the person surrounded by his home, his work, his relations, his friends, his joys, his sorrows, hopes and fears."

Francis Peabody, MD, Care of the Patient, JAMA, 1927

The REAL WORLD: the intersection between best intentions and reality….


What it can feel like…
repairing the wing of a plane as it is flying….
www.planetree.org
Documenting Patient Encounters: TOGETHER
COLLECT
DISCUSS
TARGET
CO-DESIGN
CHANGE
IMPACT
www.planetree.org
Coordinating Care: TOGETHER
The question that does not ENGAGE patients:
"Do you understand your plan of care?"
www.planetree.org



Creating a Healing Environment: TOGETHER
www.planetree.org
Empathy Mapping: TOGETHER
www.planetree.org
THANK YOU
coaching
experience
education
PLANETREE +
Our Information:
Planetree
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Derby, CT 06418
www.planetree.org
+1.203.732.1365
Jill Harrison, PhD; RYT-200
jharrison@planetree.org
@patientatcenter
www.planetree.org

Overview of Action Plan and Strategies/Turning Ideas into Action

"**Action** is the proper fruit of knowledge." English Proverb

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

ACTION PLAN for ____________ **Date** ________

Main Contact ____________ **Email** ____________ **Phone** ________

Overall Goal (What will you accomplish in next 6 months) to improve partnerships with patients and families

Action Steps To Be Taken	By When	Who Should Be Involved?	Barriers	Resources or Support Needed

How will you know it is done? What will you measure to document your progress?

Your Assignment

- **What did you learn or hear about today that excites you?**
- What **action** might you take in the next:
  - Two weeks,
  - Month or two, or
  - Six months

to **expand partnerships** with patients and families (or with your clinic) to help improve safety, quality and the experience of care.

SUCCESS

NOTES

Helping Clinicians Improve Care: The Transforming Clinical Practice Initiative (TCPI)

With support from the Centers for Medicare and Medicaid Services (CMS), the **Transforming Clinical Practice Initiative** (TCPI) is designed to assist more than 140,000 clinician practices from 2015-2019 in sharing, adapting and further developing comprehensive quality improvement strategies. This is the largest investment by the federal government in clinical transformation support with $685 million in funding allocated to 39 national and regional collaborative healthcare transformation networks and supporting organizations.

Peer-based Learning: 29 Practice Transformation Networks (PTNs) will provide technical assistance and peer-level support to assist clinicians in delivering care in a patient-centric and efficient manner. Examples include providing dedicated coaches to better manage chronic diseases, supporting patient access to practitioners through email and information technology applications, and helping improve access to remote and virtual care.

Sharing Best Practices: 10 Support and Alignment Networks (SANs) will support the PTNs by providing a system for workforce development and additional assistance with practice transformation. Examples include facilitating patient/ family partnerships in quality improvement and practice transformation; a family medicine network to provide coaching, certification and education opportunities; and creating collaborations between primary care and behavioral health clinicians to better address mental health, substance abuse, health behaviors and other environmental stressors.

To learn more about TCPI, visit the **TCPI Healthcare Communities Portal:** http://www.healthcarecommunities.org.

PCPCC's Support & Alignment Network for Patient, Caregiver & Community Engagement

The Patient-Centered Primary Care Collaborative (PCPCC; www.pcpcc.org) is a not-for-profit membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home. As a TCPI awardee, PCPCC will support practice improvement teams using our diverse network (representing clinicians, health plans, patients/families, researchers, & policymakers) to foster partnerships with patients, family caregivers and community-based organizations and achieve common goals of improved care, better health, and reduced costs.

Through our Support and Alignment Network (SAN), PCPCC will provide technical assistance to participating practices and networks to promote patient partnerships in quality improvement and community collaboration with care teams to help clinicians meet TCPI's phases of transformation.

To learn more about our SAN, visit https://pcpcc.org/tcpi or contact Jacinta Smith at jacinta@pcpcc.org.

PCPCC's SAN Grant Partners

The Institute for Patient- and Family-Centered Care (IPFCC): IPFCC will expand its existing online forum for patient/family advisors, assist in identifying best practices, provide stories about partnering with patient and family advisors in primary care improvement and transformation, and develop an orientation and training for successful partnerships.

Planetree: Planetree will provide expertise in educational development and coaching; creating patient/family-centered tools and trainings, peer-to-peer sharing, and engaging community stakeholders in transforming health care from the patients' perspective.

YMCA of the USA: YMCA of the USA will advance a model of community-integrated health in which they will promote clinic-to-community linkages to help patients improve self-management of chronic conditions using evidence-based programs and peer support and test new models of collaboration between clinicians and community-based organizations where an expanded care team will jointly share accountability for a designated patient population.

Sharing Best Practices: PCPCC's Network for Patient, Caregiver & Community Engagement

Disseminate successful strategies for practice transformation. PCPCC will work with its member organizations to connect practices to the TCPI, communicate key TCPI learnings, and develop coordinated strategies to address transformation challenges faced by clinicians. Based on the evidence derived through the TCPI, the **PCPCC Support & Alignment Network (SAN)** will:

- Disseminate practice attributes and metrics that demonstrate effective team-based care and patient/family-centered care to inform practice recognition and certification programs.
- Share successful models of primary care integration among specialty care, physician and hospital networks (including ACOs), and within communities.
- Communicate specific strategies that reduce costs and improve care quality among patient populations to a wide range of stakeholders including policymakers, purchasers and consumers.

Promote team-based care models that include patients and caregivers. Building on both evidence-based practices and innovative collaborations, PCPCC will promote strategies that result in comprehensive, team-based care that includes patients and families as meaningful partners on the team. The PCPCC SAN will:

- Disseminate tools and resources to assist in developing new staffing models that include roles for providing peer support in chronic condition management.
- Share strategies for promoting team-based care environments that foster patient and family caregiver inclusion and participation on the care team.
- Together with YMCAs and other community organizations, develop models that provide opportunities to incorporate staff from community-based organizations onto the care team.

Promote and support patient-practice partnerships. PCPCC will connect participating practices with ample support to ensure successful partnership with patients and family caregivers in clinical transformation efforts. The PCPCC SAN will:

- Track and map where clinicians have successfully engaged patients and/or family caregivers in care delivery redesign and ongoing quality improvement efforts.
- Provide training and ongoing support to patients and family caregivers participating in practice-based quality improvement activities.
- Disseminate successful stories and tools to assist clinicians in developing effective partnerships with patients and family caregivers in practice transformation.

Promote clinic-to-community linkages. PCPCC aims to help establish partnerships with community-based organizations (CBOs) offering evidence-based health management programs in their communities. The PCPCC SAN will:

- Gather and disseminate successful models of community-clinic collaborations from organizations such as YMCA, Meals on Wheels, National Council on Aging, etc.
- Facilitate communications about TCPI activities among CBOs in participating communities.
- Develop template agreements and/or best practices on ways in which clinics and local CBOs can share accountability for promoting health for defined populations within a community.