Is Person & Family Engagement the Blockbuster Drug of the 21st Century?

Prepared for
American Health Quality Association
Baltimore, June 2, 2016

Panelists
Susan Brown MPH CPHIMS -- Health IT Director, Telligen
Martin Hatlie JD -- CEO Project Patient Care
Pat Merryweather -- Executive Director, Telligen
Pat Merryweather

Susan Brown & Family

Hatlie Family
Objectives

To explore these questions:

- What’s driving PFE (= person & family engagement)?
- What’s the evidence?
- Where are the tools?
- What can we learn from users of care? Should they be driving the discussion?
- What are the learning laboratories?
- How can we be in action on PFE in our lives – professional & personal?
# Tom Evans, MD: Our “Long Journey” to Partnering with Patients

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<th>Stage 1. Working without patient input</th>
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<td>Stage 5. True partnering with patients</td>
<td>Patients bring ideas up and providers listen; providers and users of care jointly make decisions, set priorities.</td>
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Tom Evans, MD, Iowa Healthcare Collaborative
Tales from the Front

- Coordinating Reece’s team-based care
- Assessing Reece – Room for Innovation
- Medication costs – Room for Innovation
- Summary of Care and the EMR – Room for more transparency
- Teach-back for doctors
- Patient and Caregiver – We’re different persons
- Simplifying and Leaning
  - Using technology to make life simpler
  - How many portals do we need?
  - Why don’t we text more?
Creating a Winning Future
Supporting Factors

- Alignment, Integration, Collaboration, Coordination
- Expanding engagement of patients, families, consumers in health care – moving to empowerment
- Current requirements; those in development
- Providers will begin to differentiate themselves with other providers through patient experience
- Future of Healthcare
Take Bold Steps: Trusting Patient and Family Engagement and Empowerment

- Within the QIN-QIO, HENs, HIINs, provider organizations, community based organizations and settings

- QIN-QIOs have perfect opportunity to engage beneficiaries in care coordination, diabetes education, immunizations, etc.
Models Should be Designed to Get Best Results

- Listening
- Board, Council, Committee, Advisory Group
- Open discussions in public housing, assisted living, community settings, trainings
- Set a goal to have sustainable patient, family, and consumer empowerment groups
  - Go to the people; let them set the table
  - Engage in joint community health assessment, strategic plan, and action plans with the community taking leadership
Don’t Underestimate the Power of Patients, Families, and Consumers

Nsukka Cultural Zone; 1.4 million people in extreme poverty

Developing the assessment and sustainable strategic plan
One Community Focused on Agriculture as Their Health Initiative
Located in bush outside of Adani

Seek permission to speak to elders and king; village leadership attended meeting
10th Statement of Work

Talked with over 800 Medicare beneficiaries

- Small groups, police community centers, libraries, churches, Salvation Army, community based organizations identifying barriers to utilizing preventive services
10th SoW Results

- 4 Page brochure with information at their fingertips
- Opened the doors for 11th SoW diabetes and immunizations and Participation in Healthy Chicago 2.0
- NEW State of the Art Ambulatory Center in Englewood! St. Bernard Hospital worked with community and staff on needs and design
The Future is Now

Strategic International Healthcare Marketer, Michael Krivich:

“The patient experience will differentiate you.

If one focused the ad concept, copy and visuals on the patient experience and how it all fits together for the patients benefit, then you are differentiating. It is no longer about you, but about the patient. The content and context of the story are more powerful and compelling. Marketing can create a memorable and recognizable brand promise via a value equation that the consumer will understand.”
Thank you!

- **Contact**
  - Pat Merryweather [pmerryweather@telligen.com](mailto:pmerryweather@telligen.com)
  - 630-928-5860
  - [www.telligenqinqio.org](http://www.telligenqinqio.org)
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
Evolution of Patient Centered Care
the “Tribes”

- Ethics & Human Rights tribe
  - Principles of Patient Centered Care
  - Dignity & Respect
  - Inclusiveness
  - Patient Experience/HCAHPS

- IT tribe
  - e-patient Dave: *Gimme my damn data*
  - HIPPA protectors

- Chronic Care tribe

- Improvement Tribe
  - Emerging focus on outcomes improvement, now integrated and driven by federal healthcare transformation campaigns, e.g.
    - *Partnership for Patients (PfP)*
    - *Transforming Clinical Practice Initiative (TCPI)*
    - QIO programs
    - ESRD
Ethics & Human Rights Tribe

https://www.youtube.com/watch?v=2XJ5kWaPLms
IT Tribe

https://www.youtube.com/watch?v=0b4li7N_7Ck&list=PLExx37PwyTtL_p8sJPM2rxCCkXRh7uJ97&index=3
Outcomes Tribe

https://www.youtube.com/watch?v=wymoqrJlz5Q
Chronic Care Tribe

https://www.youtube.com/watch?v=sikdSUnBmos
Cleveland Clinic Video
Empathy

https://www.youtube.com/watch?v=IQtOgE2s2xI
MedStar Health

*Please See Me*

https://www.youtube.com/watch?v=380MiMDoddl
PFE Environmental Scan of Federal Transformation Efforts

- Partnership from Patients Campaigns 1.0, 2.0 & Soon to be 3.0
  - 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

- QIN-QIO SOW and Campaigns
  - Campaign for Meds Management

- Transforming Clinical Practice Initiative (TCPI)
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: Vectors

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
National Partnership for Women & Families PFE Framework
HRET’s Framework

HIMSS PFE Framework

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

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

- **Breakdowns in communication**
  - Among patient, provider, practice staff

- **Medication management**
  - Prescribing, filling, adherence, overuse

- **Diagnosis and treatment**
  - Decision making, information transfer, missed diagnosis, delayed diagnosis

- **Fragmentation and environment of care**
  - Care coordination, safety culture, reporting, error identification and management
AHRQ 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
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
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<th><strong>Point of care</strong></th>
<th><strong>Improvement work</strong></th>
<th><strong>Governance</strong></th>
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<tr>
<td><strong>PFE 1</strong>: Planning</td>
<td><strong>PFE 3</strong>: Staff with proactive PFE Responsibility</td>
<td><strong>PFE 5</strong>: Patient Representative On Board</td>
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<tr>
<td>Checklist w Patient &amp;</td>
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<td>Family</td>
<td></td>
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<tr>
<td><strong>PFE 2</strong>: Shift Change</td>
<td><strong>PFE 4</strong>: Active Patient Family Advisory Committee</td>
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<tr>
<td>Huddles/Bedside Reporting</td>
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PfP Participating Hospitals
PFE Metrics, Jul 2013 -- Nov 2014

## Advanced SAB Score: Promoting Engagement with Patients and Leaders (PEPL)

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<th>Hospital Leadership On PFP Goals</th>
<th>Hospital Structure For Patient Family Engagement</th>
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<td><strong>Governance</strong></td>
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<tr>
<td>• Public Commitment to PFP Safety, Data Transparency</td>
<td>• Patient Family Engagement (PFE) Advocate on The Board</td>
</tr>
<tr>
<td>• Board Quality Committee Reviews Safety Data</td>
<td></td>
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<tr>
<td><strong>Policy and Protocol</strong></td>
<td></td>
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<tr>
<td>• Regular Quality Review Aligned with PFP goals</td>
<td>• Active PFE Committee or Advocate</td>
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<td></td>
<td>• Staff w Proactive PFE Responsibility</td>
</tr>
<tr>
<td><strong>Point of Care</strong></td>
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<tr>
<td>• Staff Have Explicit Role in Patient Safety</td>
<td>• Pre-Admission Checklist w Patient</td>
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<td></td>
<td>• Huddles With Patient, Family</td>
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## PFE and Leadership Metrics

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<tr>
<th>PFE Metrics</th>
<th>Not All Leadership Metrics Met (N=1,172)</th>
<th>All Leadership Metrics Met (N=2,567)</th>
</tr>
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<tr>
<td>Percent hospitals meeting at least one structural PFE metric (PFE 3, 4, or 5)</td>
<td>56%</td>
<td>85%</td>
</tr>
<tr>
<td>Percent hospitals w/ leader assigned</td>
<td>39%</td>
<td>68%</td>
</tr>
<tr>
<td>Percent hospitals w/ committee/representative</td>
<td>30%</td>
<td>59%</td>
</tr>
<tr>
<td>Percent hospitals w/ representative on board</td>
<td>28%</td>
<td>54%</td>
</tr>
<tr>
<td>Average number of PFE metrics met (Nov 14)</td>
<td>1.89</td>
<td>3.31</td>
</tr>
<tr>
<td>Percent PFE opportunities met (data from Jul 13 - Nov 14)</td>
<td>27%</td>
<td>47%</td>
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</tbody>
</table>
Carolinas HealthCare “Pattern” PFE and Campaign Outcomes

Carolinas HealthCare System
Hospital Engagement Network
PSI 12: Post-operative Pulmonary Embolism or DVT PFE High Performers Analysis

- PFE High Performers - PSI 12: Post-Op Pulmonary Embolism or DVT
- PFE High Performer Baseline
- Other Cohort - PSI 12: Post-Op Pulmonary Embolism or DVT
- Other Cohort Baseline
Comparing Minnesota PPR of Low Performers (0-3 PFE) to High Performers (4-5 PFE)

- 2009: PPR ratio = 0.987
- 2011: PPR ratio = 0.817
- 2013-4: PPR ratio = 0.631

# PFE met 0-3
# PFE met 4-5
RARE Campaign: Reducing Avoidable Readmissions Effectively in Minnesota

Results:

- 7,030 readmissions avoided (as of Q3 2013)
  - Exceeded original goal of 6,000 readmissions
- Helped patients spend 24,844 more nights sleeping comfortably in their own beds
- Reduced inpatient costs by an estimated $55 million
- 2013 winner of the John M. Eisenberg Patient Safety and Quality Award for Innovation in Patient Safety and Quality
MedStar Health: HRO Roadmap

Optimized Outcomes

Reliability

10^-8
10^-7
10^-6
10^-5
10^-4
10^-3
10^-2
10^-1
10^0
10^1
10^2
10^3
10^4
10^5
10^6
10^7
10^8

- Transparency
- Patient & Family Partnerships
- Human Factors Integration
- Reliability Culture
- Process Design

- Core Values & Vertical Integration
- Hire for Fit
- Behavior Expectations for all
- Fair, Just and 200% Accountability
- Evidence-Based Best Practice
- Clinical Decision Support/IT
- Focus & Simplify
- Tactical Improvements (e.g. Bundles)

Including the Patient Voice in all we do

Intuitive design. Impossible to do the wrong thing. Obvious to do the right thing. Simulation/Innovation

Template credit to HPI
Butler Health System PFPCQS

Board of Directors

Quality & Professional Affairs Committee

Patient and Family Partnership Council for Quality and Safety

Patient Safety Committee
Vidant Health System Patient & Family Advisory Council Structure
Joe Clothier, PFAC and Hospital Quality Council Member

It is impressive to me that Logansport Memorial Hospital is excited about including patient’s input as a necessary component of their Quality Improvement Philosophy. Asking members of the community to be part of the Patient Advisory Committee, and having a Patient Advocate Council Member as a member of the Quality Council can, with time, open up needed dialogue between patients and LMH. I believe this is a huge step towards improving the level of care given to patients in the Logansport area.
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
The TCPI Change Package Structure: Expanded Driver Diagram

<table>
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<tr>
<th>Practice aims aligned with TCPI goals</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Concepts</th>
<th>Change Tactics</th>
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<td>Intended Results</td>
<td></td>
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Broad concepts that prompt specific change ideas derived from site visits/high performers

Actionable
### Drivers: Essential to Achieving TCPI Aims

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<th>Primary Drivers</th>
<th>Secondary Drivers</th>
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<td>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.</td>
<td>1.1 Patient &amp; family engagement</td>
<td>1.1 Patient &amp; family engagement</td>
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<td>2) Effective solutions moving to scale. Evidence of practice spreading effective improvement strategies to full scale for the entire population under its care.</td>
<td>1.2 Team-based relationships</td>
<td>1.2 Team-based relationships</td>
</tr>
<tr>
<td>3) High Clinical Effectiveness: Practice is effective in bringing all patient segments to their health status goals.</td>
<td>1.3 Population management</td>
<td>1.3 Population management</td>
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<td>4) Reduced Avoidable Hospital Use: Rates of readmission and unnecessary admissions for practice’s patients have been reduced.</td>
<td>1.4 Practice as a community partner</td>
<td>1.4 Practice as a community partner</td>
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<td>5) Reduced Unnecessary Testing &amp; Procedures: Practice demonstrates a reduction in unnecessary testing and in the use of the ED by its patient population.</td>
<td>1.5 Coordinated care delivery</td>
<td>1.5 Coordinated care delivery</td>
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<tr>
<td>6) Reduced costs: Practice controls its internal costs as well as other elements of total cost of care.</td>
<td>1.6 Organized, evidence based care</td>
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<td>7) Documented Value: Practice can articulate its value proposition and increases participation in available value-based payment agreements.</td>
<td>1.7 Enhanced Access</td>
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<td>2) Patient and Family-Centered Care Design</td>
<td>2.1 Engaged and committed leadership</td>
<td>2.1 Engaged and committed leadership</td>
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<td>3) Continuous, Data-Driven Quality Improvement</td>
<td>2.2 Quality improvement strategy supporting a culture of quality and safety</td>
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<td>4) Sustainable Business Operations</td>
<td>2.3 Transparent measurement and monitoring</td>
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<td>5) Reduced Avoidable Hospital Use: Rates of readmission and unnecessary admissions for practice’s patients have been reduced.</td>
<td>2.4 Optimal use of HIT</td>
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<td>6) Reduced costs: Practice controls its internal costs as well as other elements of total cost of care.</td>
<td>3.1 Strategic use of practice revenue</td>
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<td>7) Documented Value: Practice can articulate its value proposition and increases participation in available value-based payment agreements.</td>
<td>3.2 Staff vitality and joy in work</td>
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<tr>
<td></td>
<td>3.3 Capability to analyze and document value</td>
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<td></td>
<td>3.4 Efficiency of operation</td>
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Patient-Centered Medical Home (PCMH)
Bodenheimer’s PCMH Building Blocks
The chronic care model was designed in 1998 by Ed Wagner, MD, director of the MacColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound, Seattle. The Institute for Healthcare Improvement in Boston offers seminars and practice-centered training in the model, which has six components. According to IHI, they are:

**Self-management support** — Patients manage their own care.

**Decision support** — Treatment decisions are based on proven guidelines supported by at least one defining study. Health care organizations integrate proven guidelines into day-to-day practice.

**Delivery system design** — Delivery requires clear roles and tasks, and all clinicians have current information about patient status. Follow-up is standard.

**Clinical information system** — A registry or an information system that can track individual patients as well as populations is a necessity.

**Organization of health care** — Health care systems create an environment in which organized efforts improve care.

**Community** — Health care organizations make an effort to form powerful alliances and partnerships.

### The chronic care model

![Diagram of the chronic care model](image)

**Community:** Resources and policies

- Health system organization of health care
  - Self-management support
  - Delivery system design
  - Decision support
  - Clinical information systems

**Community:** Informed, activated patient

**Health system:** Productive interactions

- Prepared, proactive practice team

**Functional and clinical outcomes**

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

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<tr>
<th>Challenges (Examples)</th>
<th>Strategies for Overcoming Challenges (Examples)</th>
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<td>Physical (disability)</td>
<td>• Structured Communication (teachback, motivational interviewing)</td>
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<tr>
<td>Psychological (depression, distress)</td>
<td>• Assessment (PAM)</td>
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<tr>
<td>Cognitive (health literacy, literacy)</td>
<td>• Enhancing self-efficacy (shared goal setting &amp; action plans)</td>
</tr>
<tr>
<td>Economic (health insurance adequacy)</td>
<td>• Ongoing support (practice follow up, peer support)</td>
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<td>Social and Cultural (isolation)</td>
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8 STEPS to Building & Using Your PFAC

1. Develop your practice’s business case for PFE and ensure leadership support
2. Create a PFAC planning committee
3. Develop an action plan and charter
4. Invite, interview and select PFAC members
5. Launch the PFAC and support the members in their work as effective advisors
6. Initiate improvement projects in partnership with PFAC members
7. Track results of PFAC work
8. Celebrate PFAC successes
Mary Reeves, MD
PFACs in Small Practices

http://link.videoplatform.limelight.com/media/?mediaId=3356bff4a61443e78bb1f8d6ee2c618a&width=640&height=480&playerForm=87808a650c524ab08129c8135ce5a8ec
Goal: Stable & Resilient 3-Dimensional Structure

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

Patient and Family

Payer

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

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<th>Self-Management Of Medication: Cases and Faculty</th>
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<tr>
<td>Bruce, Connie</td>
</tr>
<tr>
<td>Teresa</td>
</tr>
<tr>
<td>Richard</td>
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<td>Gerry, Kathy</td>
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