Colorado Retina Associates
Consulting Physicians & Surgeons
for Vitreo-Retinal Disorders

Building Partnerships with Patients and Families to Improve Care

PCPCC Support and Alignment Network

Institute for Patient- and Family-Centered Care

September 11, 2018

TCPi | Transforming Clinical Practice Initiative

Today's Speaker

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

Mary Minniti, CPHQ

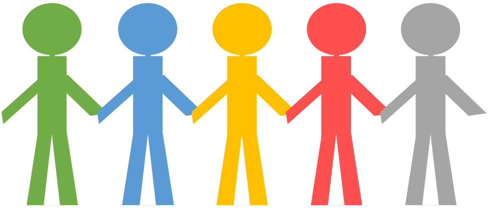
Senior Policy and Program Specialist

Objectives

- Create common understanding of patient- and family-centered care
- Explore person and family engagement metrics and strategies to achieve them
- Learn about ways to engage patients and families in improvement work
- Discuss Colorado Retina Associates opportunities to partner with patients and families

Shared Goals:
Meet the TCPI Aims

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



The PCPCC SAN: What We Do

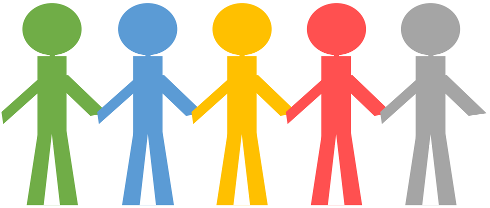
We promote deeper patient relationships and community engagement among care teams through technical assistance and other resources.

We offer the TCPI Community of Practice:

- Virtual and in-person learning events
- Scholarships to conferences and training events
- Coaching sessions for patient advisors and practices
- *Choosing Wisely* resources

- Expert faculty in the field of patient advocacy and community health to PTNs
- Online tools and resources
- PFCC.Connect: A virtual community for patient partners

Visit PCPCC for tools and Resources: http://www.pcpcc.org/tcpi



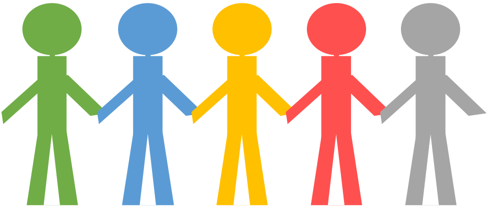
PCPCC SAN Message

Patient-Centered
Primary Care
COLLABORATIVE

Person and family engagement is a core element of effective and efficient clinical care.
When people and their families are engaged to become partners in health, it drives better outcomes, reduces costs, and improves clinician satisfaction.

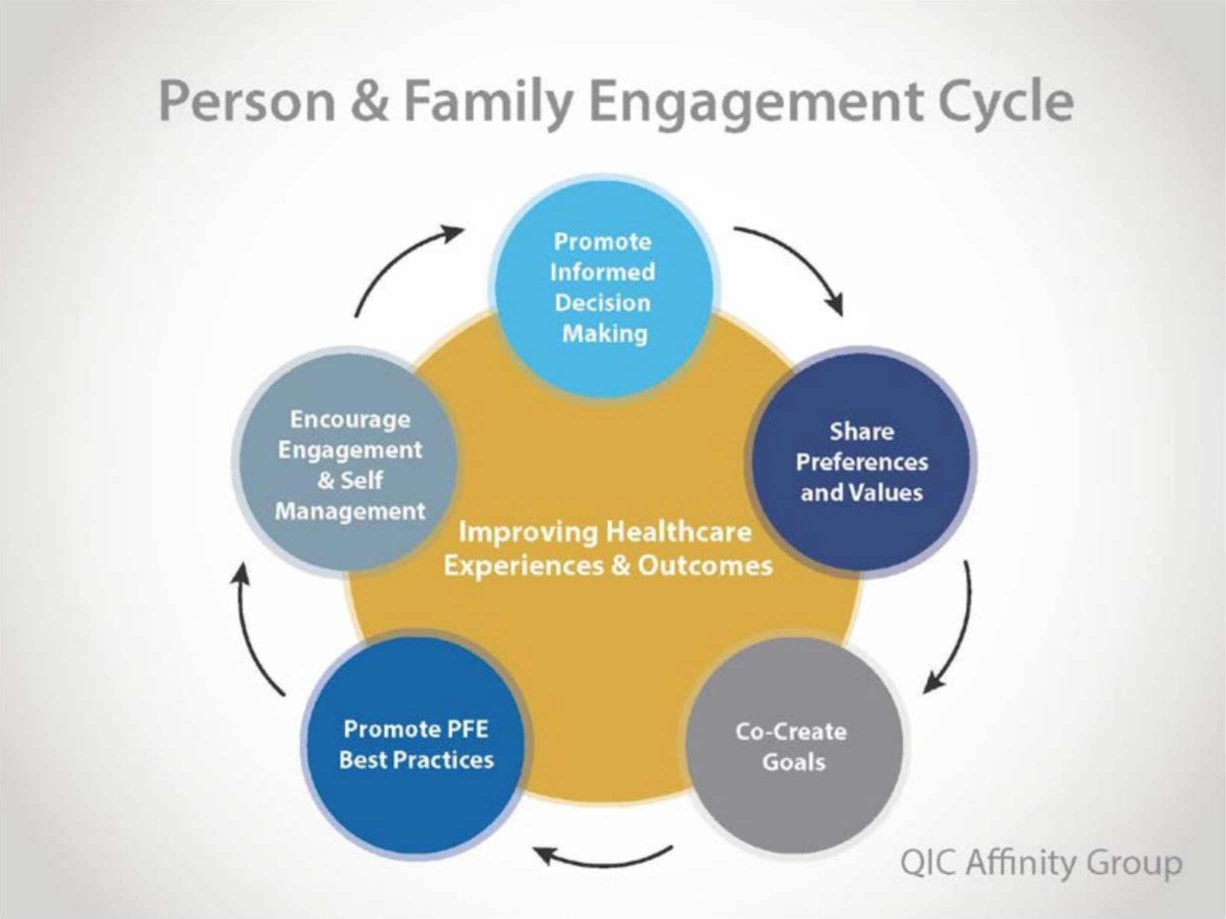
Value of the SAN: We support PTNs and clinicians to develop person, family, and community engagement capability as a transformative activity and as a tactic to meet cost and quality goals.

Opportunity: PTNs can use SAN assets to accelerate initiatives targeting cost and quality improvement. It's not "another thing to do."
TCPI PFE Metrics are integrated into PTN transformation strategies to improve adoption among targeted practices.

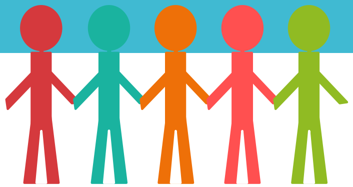


TCPi | Transforming Clinical Practice Initiative

A Strategic Framework



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Person-and-Family-Engagement.html



- Patient- and Family-Centered Care
- Person and Family Engagement
- Patient Experience

Principles of PFCC

Dignity and Respect

Information Sharing

Participation

Collaboration

- Planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships.
- Engages patients and families at direct care and operationall levels to improve outcomes, reduce harm, and enhance experiences.
- Promotes empathic relationships that seek to understand “what matters”.

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

Why Patient- and Family-Centered Care and not just Patient-Centered Care?

Individuals, who are most dependent on health care, are most dependent on families…

The very young;

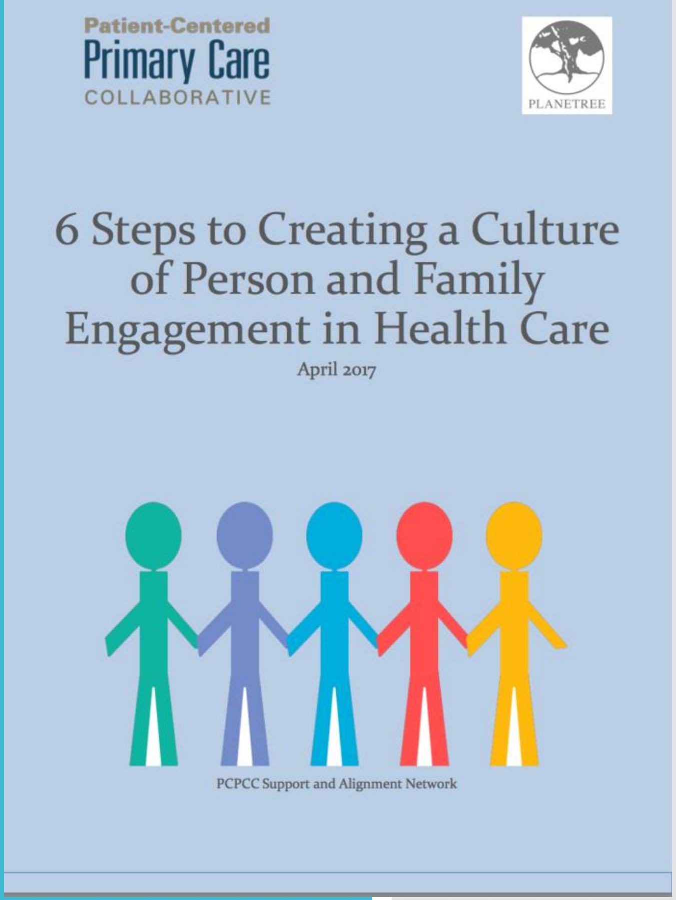
The very old; and

Those with chronic conditions.

Families can be allies for quality and safety; they often are the constant support across settings and assist with transitions of care. They can participate in the development of a care plan and support the patient in following the plan.

Cacioppo, J. T., & Hawkley, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine*, *46*(3), S39-S52.
Clark P. A., Drain, M., & Malone, M. P. (2003). Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety* 29(12), 659-70.

A Practical Resource: Continue the Conversation



Patient-Centered Primary Care COLLABORATIVE

PLANETREE

6 Steps to Creating a Culture of Person and Family Engagement in Health Care

April 2017

PCPCC Support and Alignment Network

www.pcpcc.org/resource/6-steps-creating-culture-persons-and-family-engagement-health-care

‘Blockbuster Drug’ *Patient Engagement*

FEBRUARY 2013 VOL. 32 NO. 2

Published by Project HOPE

MENTAL HEALTH
Primary Care Physicians’ Responses To Patients’ Questions Vary

NARRATIVE MATTERS
An Accidental Tourist In The Land Of Serious Illness by Jessie C. Gruman

STATUS REPORT
State Consumer Assistance Programs For Insurance Under Health Reform

AT THE INTERSECTION OF HEALTH, HEALTH CARE, AND POLICY

HealthAffairs

New Era Of Patient Engagement

The Evidence On Patient Activation
Judith H. Hibbard & Jessica Greene
PLUS *A Framework For Interventions And Policies*
Kristin L. Carman et al.
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Creating A Health Literate Care Model
Howard K. Koh et al.
Page 357

Engaging Patients In Patient-Centered Outcomes Research
Rachael Fleurence et al.
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Leading Health System CEOs Offer Strategies
Delos M. Cosgrove et al.
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Barriers To Adoption Of Shared Decision Making In Primary Care
Mark W. Friedberg et al.
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Providing Patients With Data On Costs And Physician Quality
Jill Mathews Yegian et al.
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Supporting Engagement Via E-Health
Lygeia Ricciardi et al.
PLUS *Why Patients Aren’t Up To Engagement—And Better Strategies For Behavior Change*
Robert F. Nease et al.
Page 376

PLUS:
Having The Ultimate Conversation: The Conversation Project
Maureen Bisognano & Ellen Goodman

WWW.HEALTHAFFAIRS.ORG

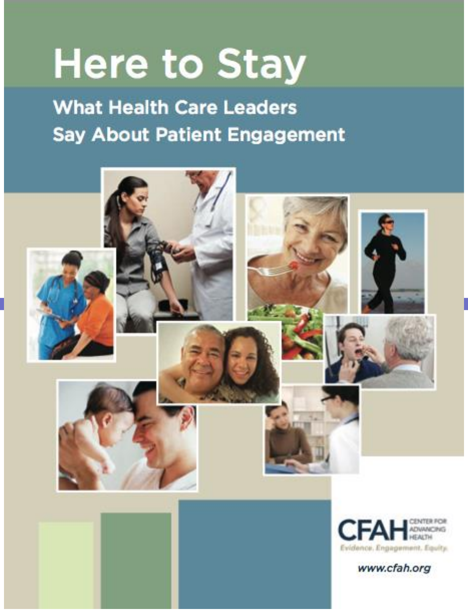
“Engagement broadly defined is an

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

Patient Engagement



Here to Stay

What Health Care Leaders Say About Patient Engagement

CFAH CENTER FOR ADVANCING HEALTH

Evidence. Engagement. Equity.

www.cfah.org

"…actions individuals must take to obtain the greatest benefit from the health care services available to them."

Center for the Advancement of Health, 2010

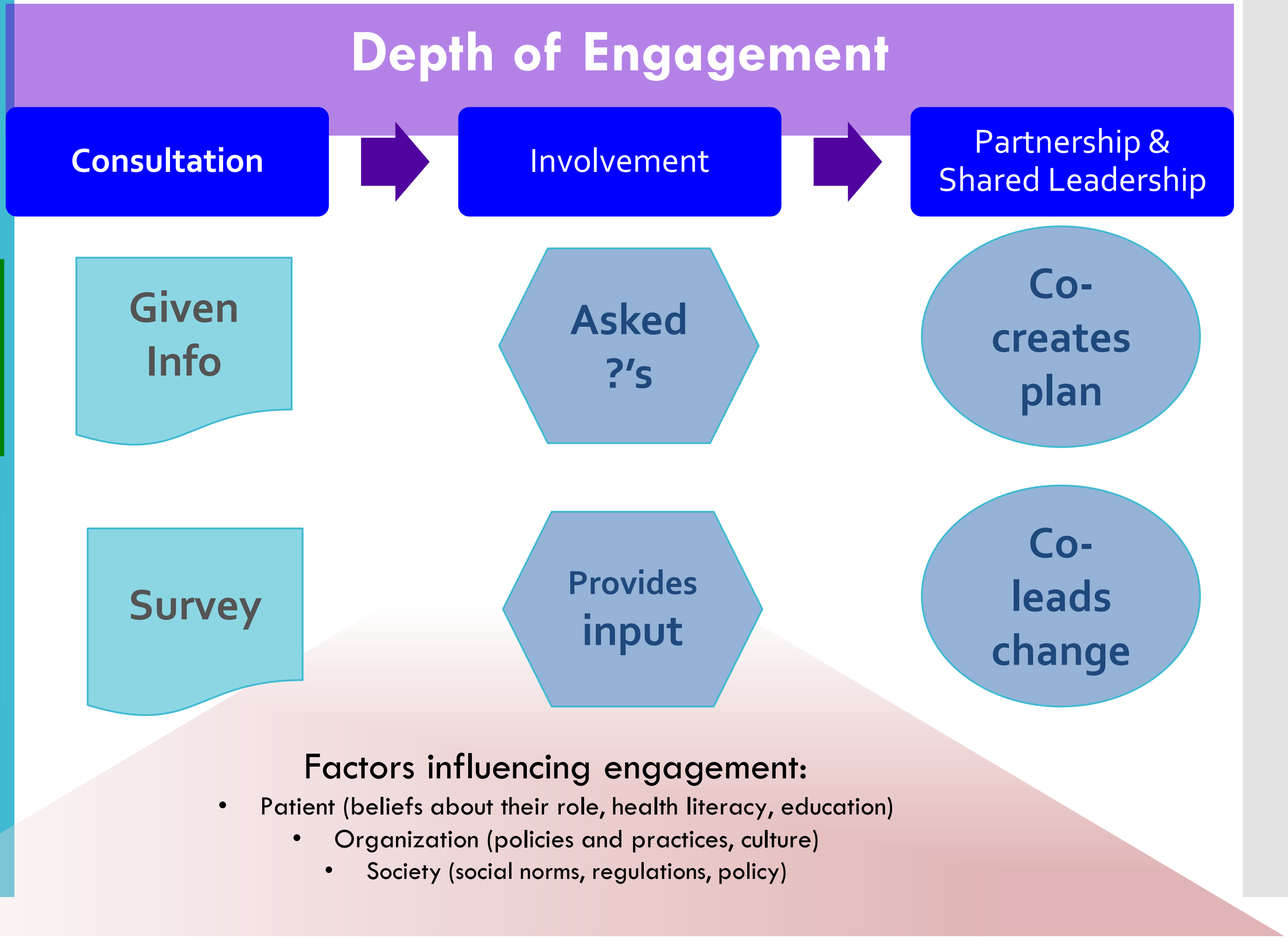
http://www.cfah.org

http://www.cfah.org/fileCFAH_PACT_WhitePaper_current.pdf

Cindy's Story

"Actively Engaged in Her Health"

Continuum of Patient Engagement

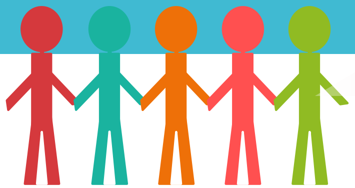


Depth of Engagement

	Consultation →	Involvement →	Partnership & Shared Leadership
Direct Care	**Given Info**	**Asked ?'s**	**Co-creates plan**
Organizational Design & Governance	**Survey**	**Provides input**	**Co-leads change**

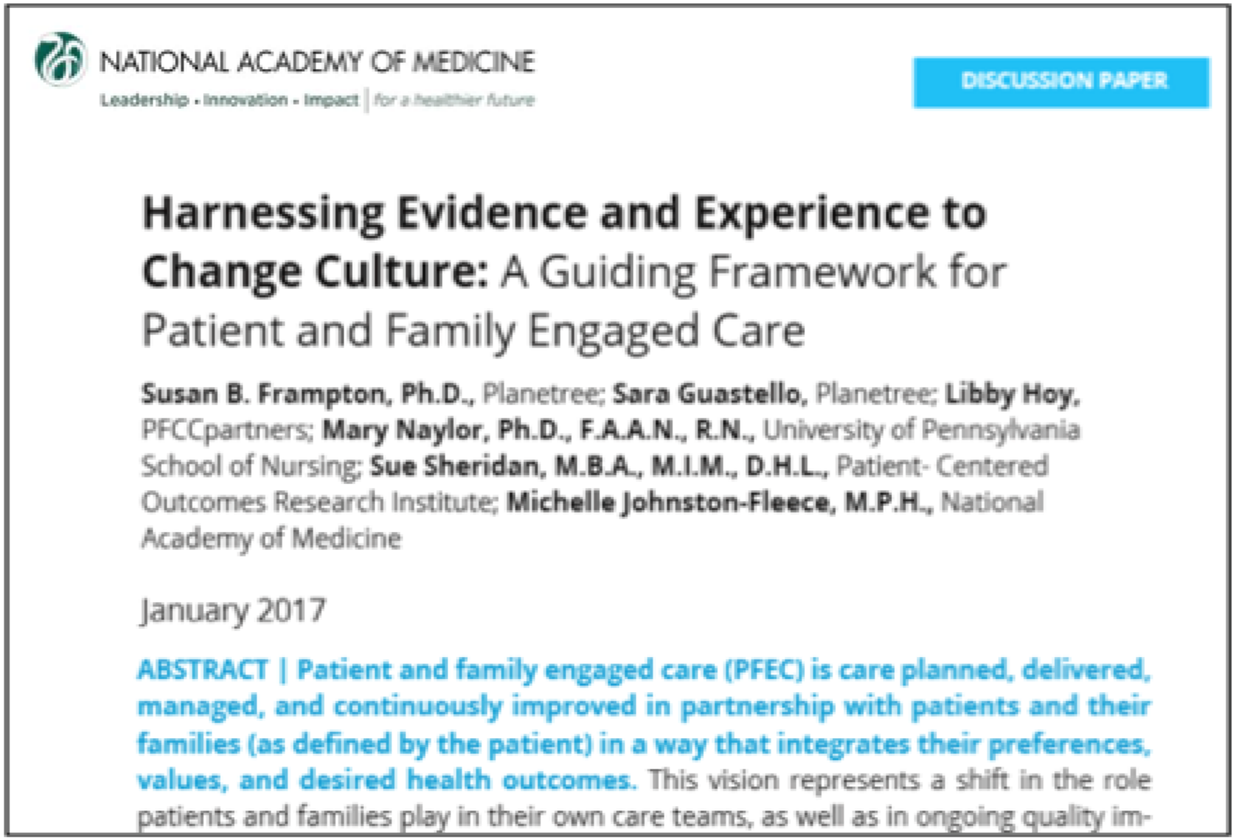
Factors influencing engagement:

- Patient (beliefs about their role, health literacy, education)
- Organization (policies and practices, culture)
- Society (social norms, regulations, policy)



Kristin L. Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel and Jennifer Sweeney Patient And Family Engagement: A Framework For Understanding The Elements And Developing Interventions And Policies doi: 10.1377/hlthaff.2012.1133 *Health Affairs* 32, no.2 (2013):223-231

Extensive Evidence on PFE



NATIONAL ACADEMY OF MEDICINE
Leadership · Innovation · Impact | *for a healthier future*

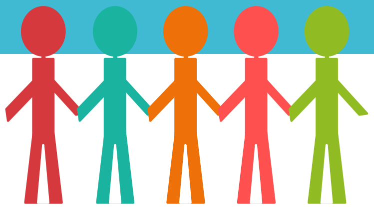
DISCUSSION PAPER

Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care

Susan B. Frampton, Ph.D., Planetree; **Sara Guastello,** Planetree; **Libby Hoy,** PFCCpartners; **Mary Naylor, Ph.D., F.A.A.N., R.N.,** University of Pennsylvania School of Nursing; **Sue Sheridan, M.B.A., M.I.M., D.H.L.,** Patient- Centered Outcomes Research Institute; **Michelle Johnston-Fleece, M.P.H.,** National Academy of Medicine

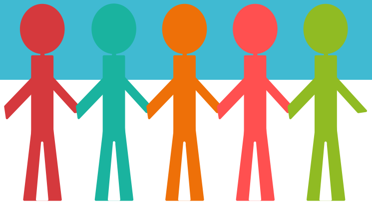
January 2017

ABSTRACT | Patient and family engaged care (PFEC) is care planned, delivered, managed, and continuously improved in partnership with patients and their families (as defined by the patient) in a way that integrates their preferences, values, and desired health outcomes. This vision represents a shift in the role patients and families play in their own care teams, as well as in ongoing quality im-



Compelling Evidence

- Improvement in staff experience, retention, reduction in job stress and burnout
- Improved transitions of care, decrease in unnecessary readmissions
- Increased patient and family success in self- management, improved quality of life, reduced illness burden
- Reduced rates of hospitalization, emergency room utilization, shorter LOS and cost per case



Patient-Centered
Primary Care
COLLABORATIVE

Person and Family Engagement Performance Metrics

Governance

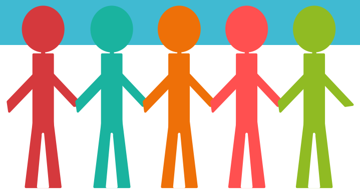
- Support for Patient and Family Voices

Point of Care

- Shared Decision Making
- E-tool Use

Policy and Procedure

- Patient Activation
- Health Literacy Survey
- Medication Management



Support for Patient and Family Voices

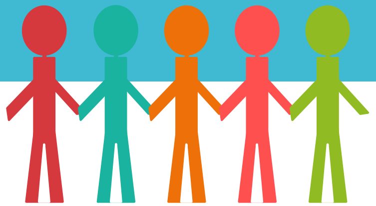
Are there policies, procedures, and actions taken to support patient and family participation in governance or operational decision-making of the practice (Patient and Family Advisory Councils (PFAC), Practice Improvement Teams, Board Representatives, etc.)?

Intent: The intent of this metric is to include the perspective and voice of the patient and family in all aspects of the governance/operation of the practice.

Key Lever for Transformational Change

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

Have you considered…

Inviting patients and family to participate on an improvement team?

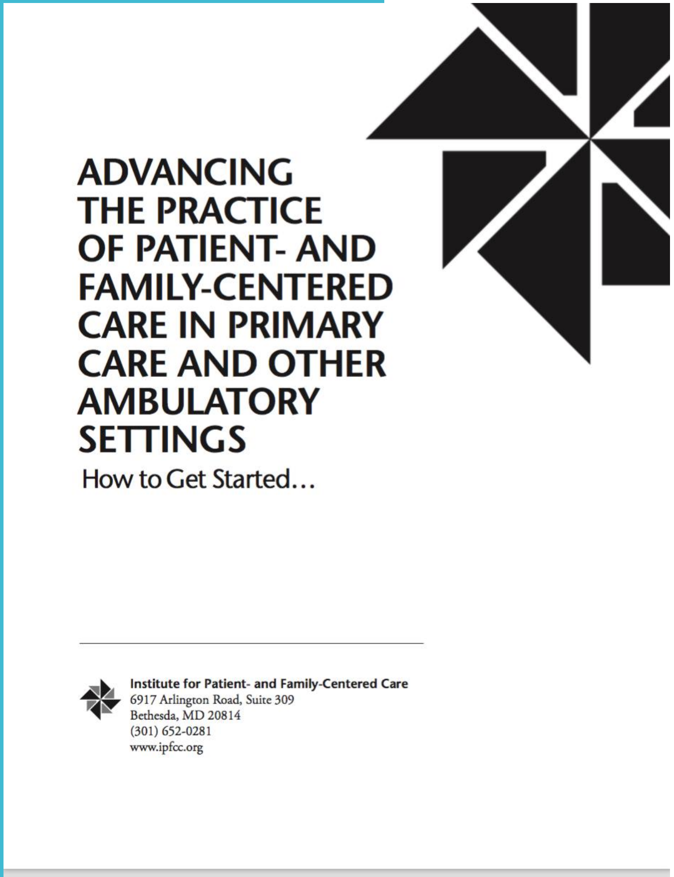
Establishing a Patient and Family Advisory Council?

Inviting advisors to walk through the clinic and share observations of what engages them and what is not welcoming and supportive of their participation?

Polling patients and families about a change you are considering?

Seeking input on educational or informational materials?

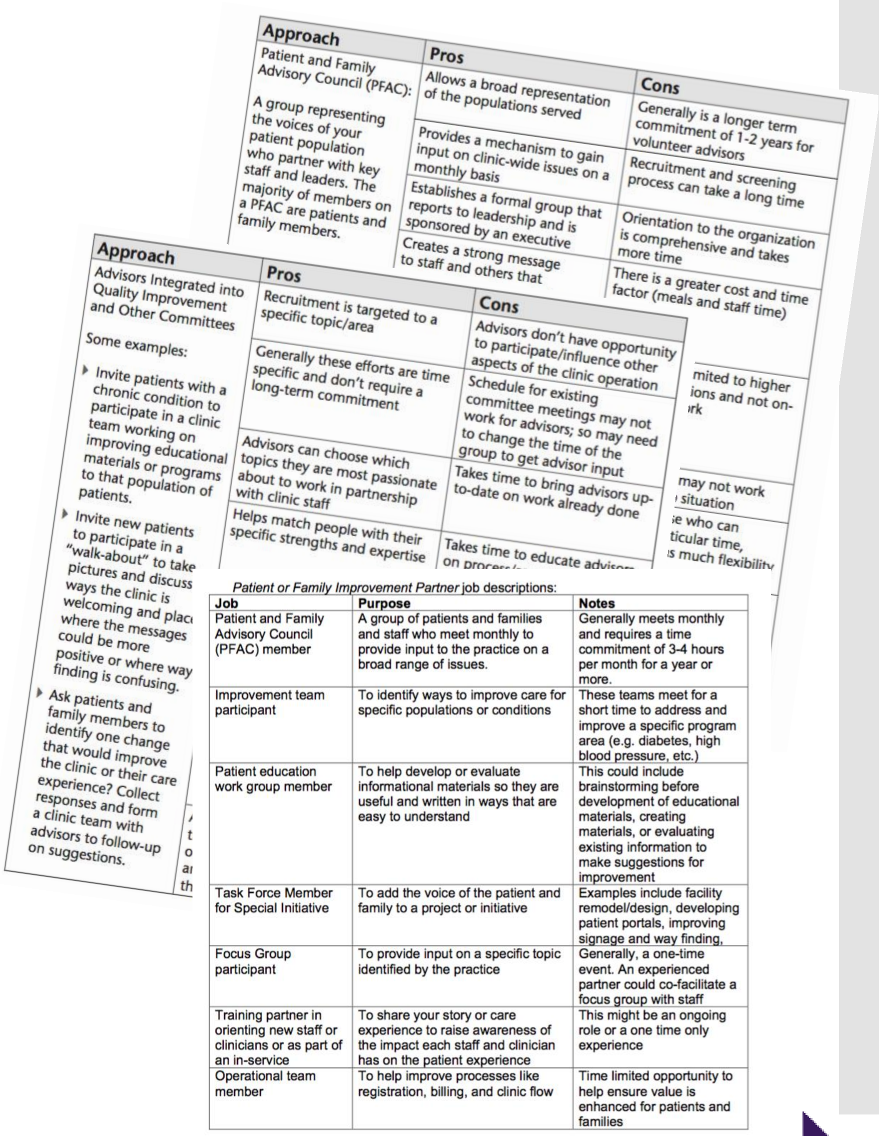
Support for Patient and Family Voices



ADVANCING THE PRACTICE OF PATIENT- AND FAMILY-CENTERED CARE IN PRIMARY CARE AND OTHER AMBULATORY SETTINGS

How to Get Started…

Institute for Patient- and Family-Centered Care
6917 Arlington Road, Suite 309
Bethesda, MD 20814
(301) 652-0281
www.ipfcc.org



Approach	Pros	Cons
Patient and Family Advisory Council (PFAC): A group representing the voices of your patient population who partner with key staff and leaders. The majority of members on a PFAC are patients and family members.	Allows a broad representation of the populations served	Generally is a longer term commitment of 1-2 years for volunteer advisors
	Provides a mechanism to gain input on clinic-wide issues on a monthly basis	Recruitment and screening process can take a long time
	Establishes a formal group that reports to leadership and is sponsored by an executive	Orientation to the organization is comprehensive and takes more time
	Creates a strong message to staff and others that	There is a greater cost and time factor (meals and staff time)
		mited to higher ions and not on- rk
		may not work situation
		se who can ticular time, s much flexibility

Approach	Pros	Cons
Advisors Integrated into Quality Improvement and Other Committees Some examples: ‣ Invite patients with a chronic condition to participate in a clinic team working on improving educational materials or programs to that population of patients. ‣ Invite new patients to participate in a "walk-about" to take pictures and discuss ways the clinic is welcoming and place where the messages could be more positive or where way finding is confusing. ‣ Ask patients and family members to identify one change that would improve the clinic or their care experience? Collect responses and form a clinic team with advisors to follow-up on suggestions.	Recruitment is targeted to a specific topic/area	Advisors don't have opportunity to participate/influence other aspects of the clinic operation
	Generally these efforts are time specific and don't require a long-term commitment	Schedule for existing committee meetings may not work for advisors; so may need to change the time of the group to get advisor input
	Advisors can choose which topics they are most passionate about to work in partnership with clinic staff	Takes time to bring advisors up-to-date on work already done
	Helps match people with their specific strengths and expertise	Takes time to educate advisors on process/

Patient or Family Improvement Partner job descriptions:

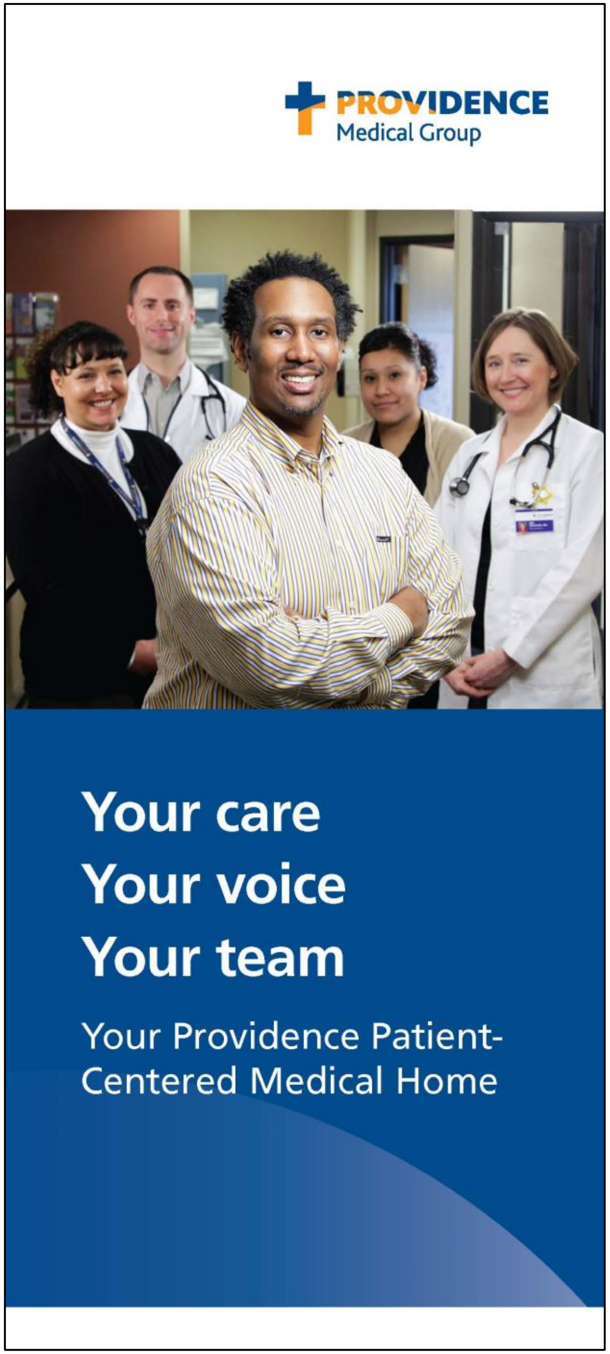
Job	Purpose	Notes
Patient and Family Advisory Council (PFAC) member	A group of patients and families and staff who meet monthly to provide input to the practice on a broad range of issues.	Generally meets monthly and requires a time commitment of 3-4 hours per month for a year or more.
Improvement team participant	To identify ways to improve care for specific populations or conditions	These teams meet for a short time to address and improve a specific program area (e.g. diabetes, high blood pressure, etc.)
Patient education work group member	To help develop or evaluate informational materials so they are useful and written in ways that are easy to understand	This could include brainstorming before development of educational materials, creating materials, or evaluating existing information to make suggestions for improvement
Task Force Member for Special Initiative	To add the voice of the patient and family to a project or initiative	Examples include facility remodel/design, developing patient portals, improving signage and way finding,
Focus Group participant	To provide input on a specific topic identified by the practice	Generally, a one-time event. An experienced partner could co-facilitate a focus group with staff
Training partner in orienting new staff or clinicians or as part of an in-service	To share your story or care experience to raise awareness of the impact each staff and clinician has on the patient experience	This might be an ongoing role or a one time only experience
Operational team member	To help improve processes like registration, billing, and clinic flow	Time limited opportunity to help ensure value is enhanced for patients and families

http://www.ipfcc.org/resources/GettingStarted-AmbulatoryCare.pdf

Patients and Family as Implementation Partners

Patient-Centered Medical Home Brochure

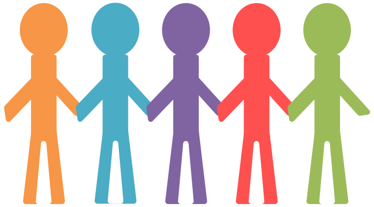
- Created in partnership with Patient & Family Advisors, Providers, Health Educators
- Language is understandable, translated into 5 languages, has patients individual clinic information on the back



PROVIDENCE
Medical Group

Your care
Your voice
Your team

Your Providence Patient-Centered Medical Home



Patient-Centered
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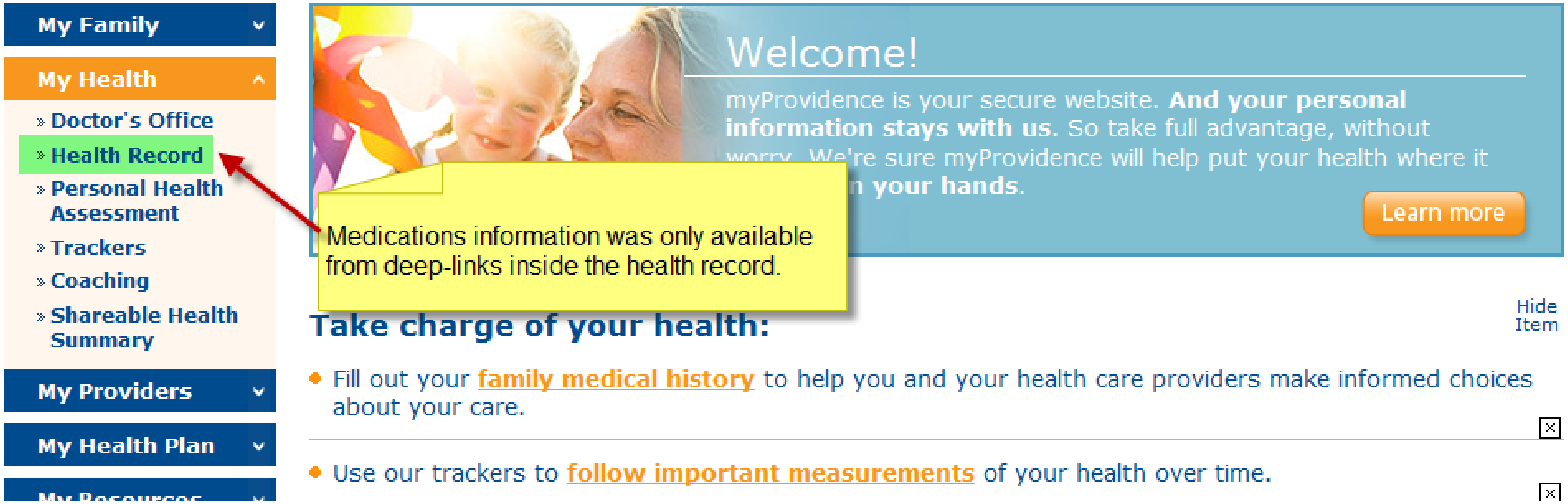
Access to Medications Info

Before



Welcome!

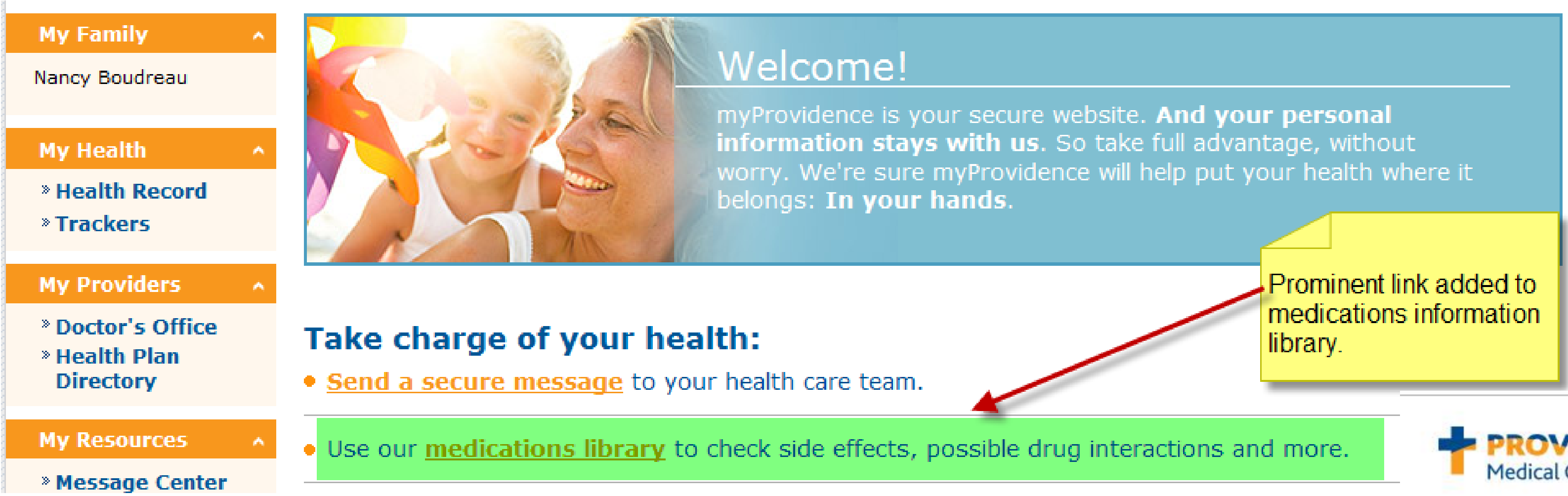
myProvidence is your secure website. **And your personal information stays with us.** So take full advantage, without worry. We're sure myProvidence will help put your health where it … **n your hands.**

Take charge of your health:

- Fill out your family medical history to help you and your health care providers make informed choices about your care.
- Use our trackers to follow important measurements of your health over time.

Medications information was only available from deep-links inside the health record.

After



Welcome!

myProvidence is your secure website. **And your personal information stays with us.** So take full advantage, without worry. We're sure myProvidence will help put your health where it belongs: **In your hands.**

Take charge of your health:

- Send a secure message to your health care team.
- Use our medications library to check side effects, possible drug interactions and more.

Prominent link added to medications information library.

PROVIDENCE
Medical Group

Working in Partnership across Sites

Executive PFAC chartered subcommittee

Clinic PFAC members recruited to serve on subcommittee

Poster created out of subcommittee work to be used system-wide

PFAC

PROVIDENCE Health & Services

Many Things Affect Your Pain

Pain is complex and everybody experiences pain differently.

Here are some things to consider to help you reduce your pain:

Do you understand the brain's role when you feel pain?

Do you know how to manage stress?

Are you doing the things you enjoy?

Are you getting the right amount of sleep?

Are you up and moving around?

Are you eating a healthy diet?

Medication is only one part of your care plan.
Talk with your medical home care team about options for changing your pain experience.

Outcomes and Benefits

- 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.
- Patients/Families are motivators – provide hope and dampens cynicism
- Reduces burden for healthcare team
- Creates better tools to meet patient needs and “activate” patients as full partners
- Provides information to help make better business decisions
- Broadens perspectives – acting into new ways of thinking

Shared Decision Making

Does the practice support shared decision-making by training and ensuring that clinical teams integrate patient-identified goals, preferences, outcomes, and concerns into the treatment plan (e.g. those based on the individual's culture, language, spiritual, social determinants, etc.)?

Intent: The intent of this metric is to ensure that patients (and their families according to patient preference) are authentically part of the care team.

Shared Decision-Making – Individual

- Set the stage by understanding and documenting patient preferences:
  - Preferred language
  - How to receive information
  - About loved one's involvement in care
- Invite patient participation
  - What are your priorities today?
  - What matters to you about this new diagnosis?
- Encourage family member presence at medical appointments
- Offer options in treatment approaches
- Show appreciation for their active participation

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. A., Brown, J. B., Donner, A., McWhinney, I. R., Oates, J., Weston, W. W., et al. (2000). The impact of patient-centered care on outcomes, *Journal of Family Medicine*, *49*(9), 796-804.

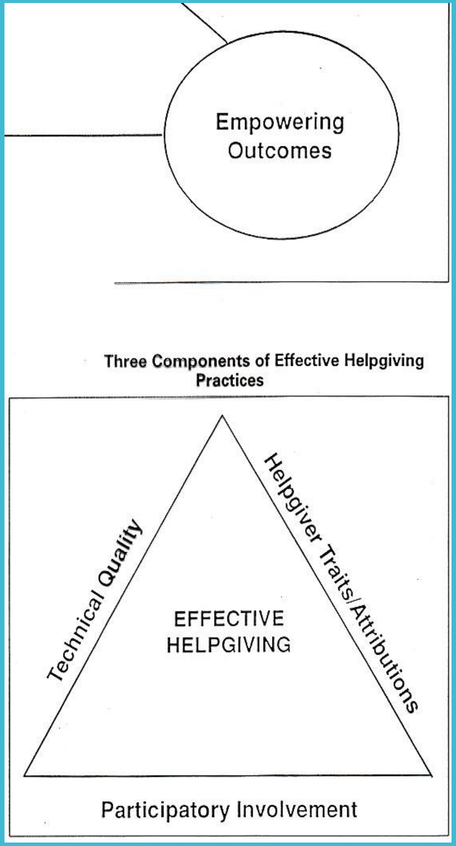
Family Presence at Medical Appointments

Improved Outcomes

Medicare study compared experience of care for patients accompanied by family to unaccompanied patients. Positive observations included:

- Health care providers engaged in more biomedical information giving.
- Family facilitated communication, provided information on medical needs or conditions, helped explain physician instructions.
- Patients were more highly satisfied with physician's technical, information giving and interpersonal skills even though they had worst self-rated health.

Wolff, J. L. & Roter, D .L. (2011). Family presence in routine medical visits: A meta-analytical review**,** *Social Science & Medicine*, *72*(6), 823-831.



Three Components of Effective Helpgiving Practices

Effective help giving is not simply a matter of whether the individual’s needs are met, but **is in the *manner* in which** they are met.

Trivette, C. M., Dunst, C. J., & Hamby, D. W. (1996). Characteristics and consequences of helpgiving practices in contrasting human services programs. *American Journal of Community Psychology*, 1996.

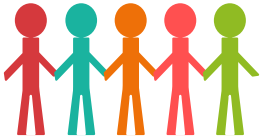
Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2007). *A matter of family-centered helpgiving practices.* Asheville, NC: Winterberry Press.

Communicating Via Decision Aids

Studies have shown that 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect.

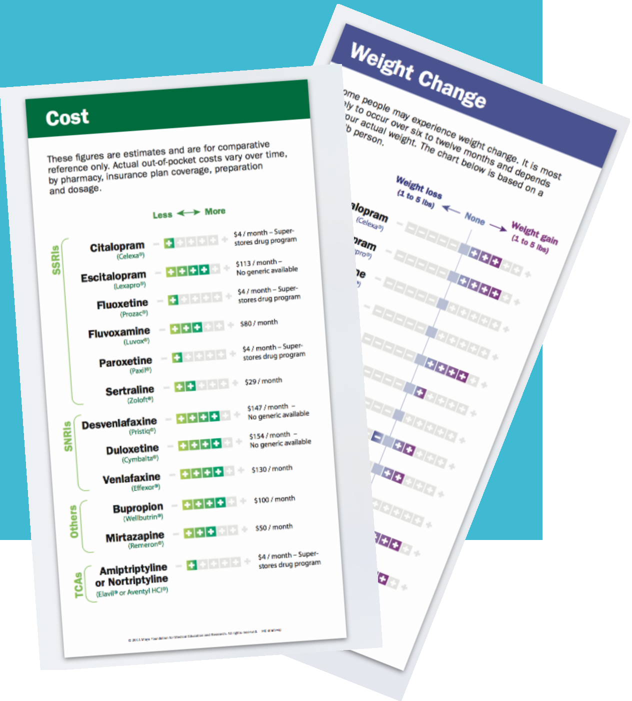
A 2011 analysis of 86 randomized clinical trials concluded that **decision aids** make patients ***better informed, improve communication with doctors, and increase participation in decisions*** about their care.

Stacey, D., et al. Decision aids for people facing health treatment or screening decisions. Chochrane Database Syst Rev, 2011.



Shared Decision-Making – Clinic Readiness

- Explore Shared decision-making training for staff and clinicians
- Determine your top 3 clinical conditions
- Research available shared decision-making tools
- Invite patients and family with lived experience to share it and provide input about tools under consideration
- Develop a sustainable process that outlines team roles



Cost

These figures are estimates and are for comparative reference only. Actual out-of-pocket costs vary over time, by pharmacy, insurance plan coverage, preparation and dosage.

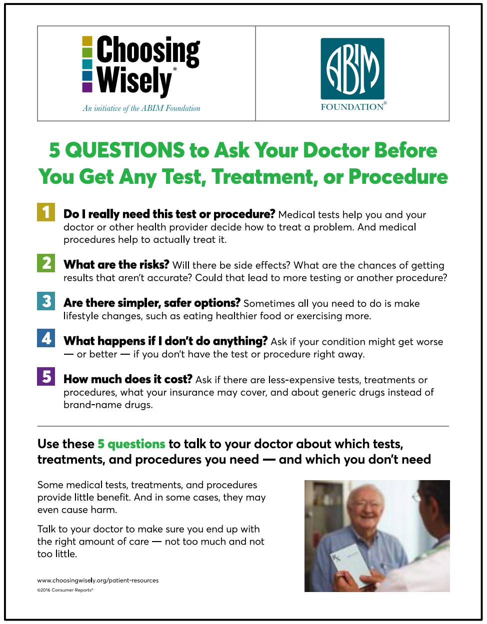
		Less ⟷ More	
SSRIs	**Citalopram** (Celexa®)	🟩⬜⬜⬜⬜	$4 / month – Super-stores drug program
	Escitalopram (Lexapro®)	🟩🟩🟩🟩⬜	$113 / month – No generic available
	Fluoxetine (Prozac®)	🟩⬜⬜⬜⬜	$4 / month – Super-stores drug program
	Fluvoxamine (Luvox®)	🟩🟩🟩⬜⬜	$80 / month
	Paroxetine (Paxil®)	🟩⬜⬜⬜⬜	$4 / month – Super-stores drug program
	Sertraline (Zoloft®)	🟩🟩⬜⬜⬜	$29 / month
SNRIs	**Desvenlafaxine** (Pristiq®)	🟩🟩🟩🟩⬜	$147 / month – No generic available
	Duloxetine (Cymbalta®)	🟩🟩🟩🟩⬜	$154 / month – No generic available
	Venlafaxine (Effexor®)	🟩🟩🟩🟩⬜	$130 / month
Others	**Bupropion** (Wellbutrin®)	🟩🟩🟩🟩⬜	$100 / month
	Mirtazapine (Remeron®)	🟩🟩🟩⬜⬜	$50 / month
TCAs	**Amiptriptyline or Nortriptyline** (Elavil® or Aventyl HCl®)	🟩⬜⬜⬜⬜	$4 / month – Super-stores drug program

Weight Change

Weight loss (1 to 5 lbs) ← None → Weight gain (1 to 5 lbs)

http://shareddecisions.mayoclinic.org

Questions to Ask your Doctor:
Several resources with similar messaging, and all easy to use.



Choosing Wisely®

An initiative of the ABIM Foundation

ABIM FOUNDATION®

5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1. **Do I really need this test or procedure?** Medical tests help you and your doctor or other health provider decide how to treat a problem. And medical procedures help to actually treat it.
2. **What are the risks?** Will there be side effects? What are the chances of getting results that aren't accurate? Could that lead to more testing or another procedure?
3. **Are there simpler, safer options?** Sometimes all you need to do is make lifestyle changes, such as eating healthier food or exercising more.
4. **What happens if I don't do anything?** Ask if your condition might get worse — or better — if you don't have the test or procedure right away.
5. **How much does it cost?** Ask if there are less-expensive tests, treatments or procedures, what your insurance may cover, and about generic drugs instead of brand-name drugs.

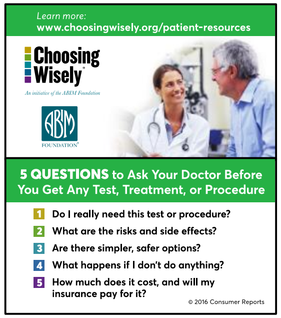
Use these 5 questions to talk to your doctor about which tests, treatments, and procedures you need — and which you don't need

Some medical tests, treatments, and procedures provide little benefit. And in some cases, they may even cause harm.

Talk to your doctor to make sure you end up with the right amount of care — not too much and not too little.

www.choosingwisely.org/patient-resources

Brochures / Posters



Learn more:
www.choosingwisely.org/patient-resources

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4. What happens if I don't do anything?
5. How much does it cost, and will my insurance pay for it?

Wallet Cards

Don't know what to ask your health care provider? Here are 5 QUESTIONS.

1. Do I really need this test or procedure?
2. What are the risks and side effects?
3. Are there simpler, safer options?
4. What happens if I don't do anything?
5. How much does it cost, and will my insurance pay for it?

Rack Cards

Videos

Inviting Patient and Family Participation

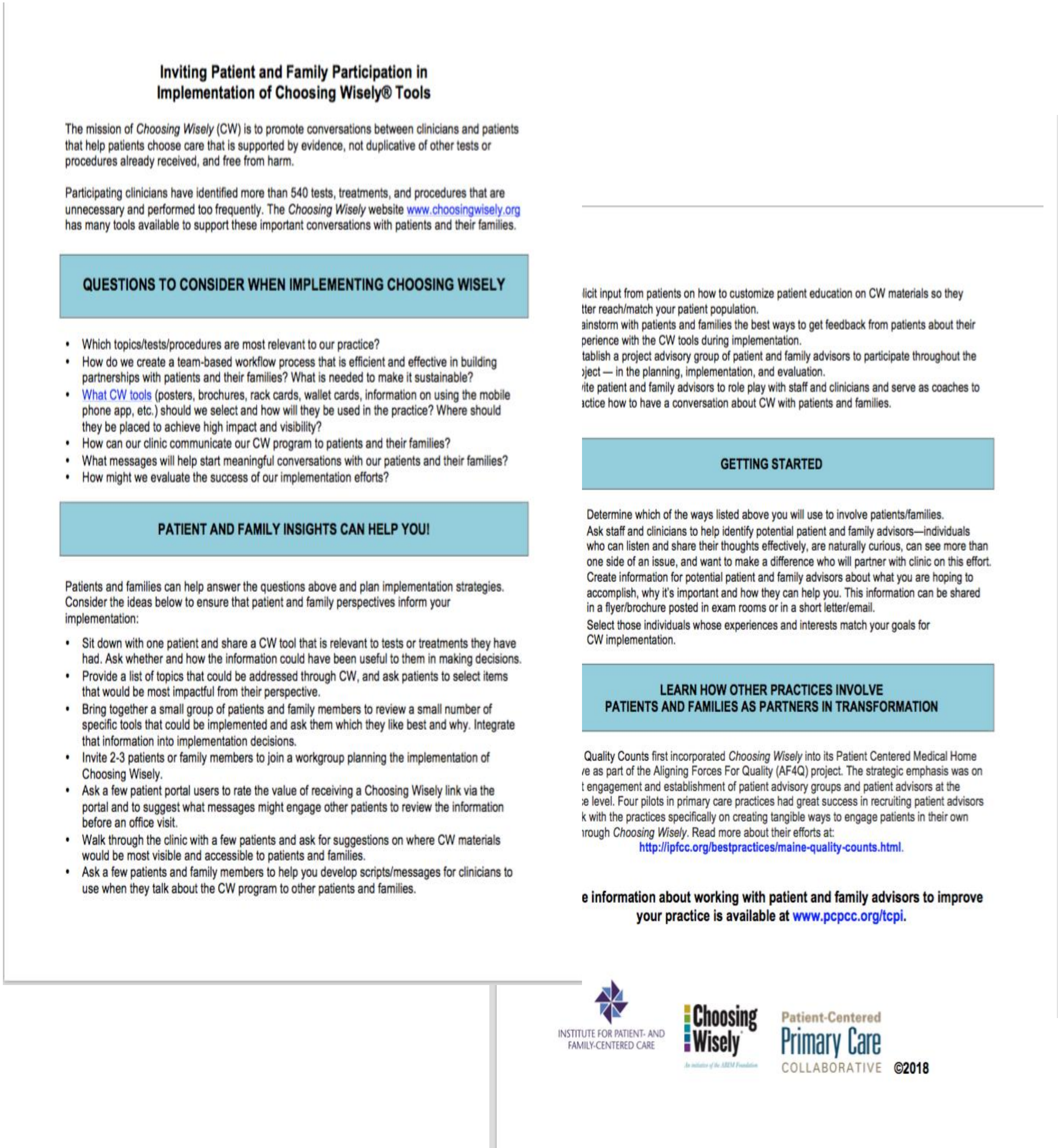
Patients and families bring insights about:

- How to introduce practice changes to better engage others
- What Choosing Wisely tools are most useful to them
- Where to place materials/tools to increase visibility
- Which messages will build shared decision-making partnerships
- How to evaluate success of implementation

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

Patient-Centered
Primary Care
COLLABORATIVE

Implementation of Choosing Wisely with Patient and Family Participation



Inviting Patient and Family Participation in Implementation of Choosing Wisely® Tools

The mission of *Choosing Wisely* (CW) is to promote conversations between clinicians and patients that help patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, and free from harm.

Participating clinicians have identified more than 540 tests, treatments, and procedures that are unnecessary and performed too frequently. The *Choosing Wisely* website www.choosingwisely.org has many tools available to support these important conversations with patients and their families.

QUESTIONS TO CONSIDER WHEN IMPLEMENTING CHOOSING WISELY

- Which topics/tests/procedures are most relevant to our practice?
- How do we create a team-based workflow process that is efficient and effective in building partnerships with patients and their families? What is needed to make it sustainable?
- What CW tools (posters, brochures, rack cards, wallet cards, information on using the mobile phone app, etc.) should we select and how will they be used in the practice? Where should they be placed to achieve high impact and visibility?
- How can our clinic communicate our CW program to patients and their families?
- What messages will help start meaningful conversations with our patients and their families?
- How might we evaluate the success of our implementation efforts?

PATIENT AND FAMILY INSIGHTS CAN HELP YOU!

Patients and families can help answer the questions above and plan implementation strategies. Consider the ideas below to ensure that patient and family perspectives inform your implementation:

- Sit down with one patient and share a CW tool that is relevant to tests or treatments they have had. Ask whether and how the information could have been useful to them in making decisions.
- Provide a list of topics that could be addressed through CW, and ask patients to select items that would be most impactful from their perspective.
- Bring together a small group of patients and family members to review a small number of specific tools that could be implemented and ask them which they like best and why. Integrate that information into implementation decisions.
- Invite 2-3 patients or family members to join a workgroup planning the implementation of Choosing Wisely.
- Ask a few patient portal users to rate the value of receiving a Choosing Wisely link via the portal and to suggest what messages might engage other patients to review the information before an office visit.
- Walk through the clinic with a few patients and ask for suggestions on where CW materials would be most visible and accessible to patients and families.
- Ask a few patients and family members to help you develop scripts/messages for clinicians to use when they talk about the CW program to other patients and families.

licit input from patients on how to customize patient education on CW materials so they
tter reach/match your patient population.
ainstorm with patients and families the best ways to get feedback from patients about their
perience with the CW tools during implementation.
tablish a project advisory group of patient and family advisors to participate throughout the
oject — in the planning, implementation, and evaluation.
ite patient and family advisors to role play with staff and clinicians and serve as coaches to
actice how to have a conversation about CW with patients and families.

GETTING STARTED

Determine which of the ways listed above you will use to involve patients/families.
Ask staff and clinicians to help identify potential patient and family advisors—individuals who can listen and share their thoughts effectively, are naturally curious, can see more than one side of an issue, and want to make a difference who will partner with clinic on this effort.
Create information for potential patient and family advisors about what you are hoping to accomplish, why it's important and how they can help you. This information can be shared in a flyer/brochure posted in exam rooms or in a short letter/email.
Select those individuals whose experiences and interests match your goals for CW implementation.

LEARN HOW OTHER PRACTICES INVOLVE PATIENTS AND FAMILIES AS PARTNERS IN TRANSFORMATION

Quality Counts first incorporated *Choosing Wisely* into its Patient Centered Medical Home
ve as part of the Aligning Forces For Quality (AF4Q) project. The strategic emphasis was on
t engagement and establishment of patient advisory groups and patient advisors at the
e level. Four pilots in primary care practices had great success in recruiting patient advisors
k with the practices specifically on creating tangible ways to engage patients in their own
rough *Choosing Wisely*. Read more about their efforts at:
http://ipfcc.org/bestpractices/maine-quality-counts.html.

e information about working with patient and family advisors to improve
your practice is available at www.pcpcc.org/tcpi.

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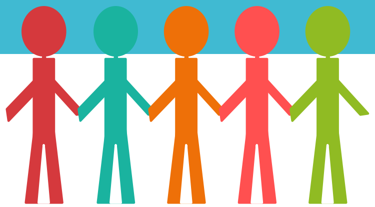
Choosing Wisely
Patient-Centered Primary Care COLLABORATIVE ©2018



E-Tool Use

Does the practice use an e-tool (patient portal or other e-connectivity technology) that is accessible to both patients and clinicians and that shares information such as test results, medication list, vitals, and other information and patient record data?

Intent: The intent of this metric is to have an electronic tool that allows patients to access their medical record and have an easy, direct way to communicate with providers.

How Well Is Your Portal Utilized?

- Designate staff to act as Patient Portal Champions
- Identify a portal technical support who available to patients
- Set goals between teams on portal usage and make progress transparent

If adoption is low,
consider increasing functionality!

Access to Information Patient Portals

Send a refill request for any of your refillable medications

OpenNotes®

Studies have shown that 40-80% of the medical information patients are told during office visits is forgotten immediately, and nearly half of the information retained is incorrect.

https://www.opennotes.org/

Patient Activation

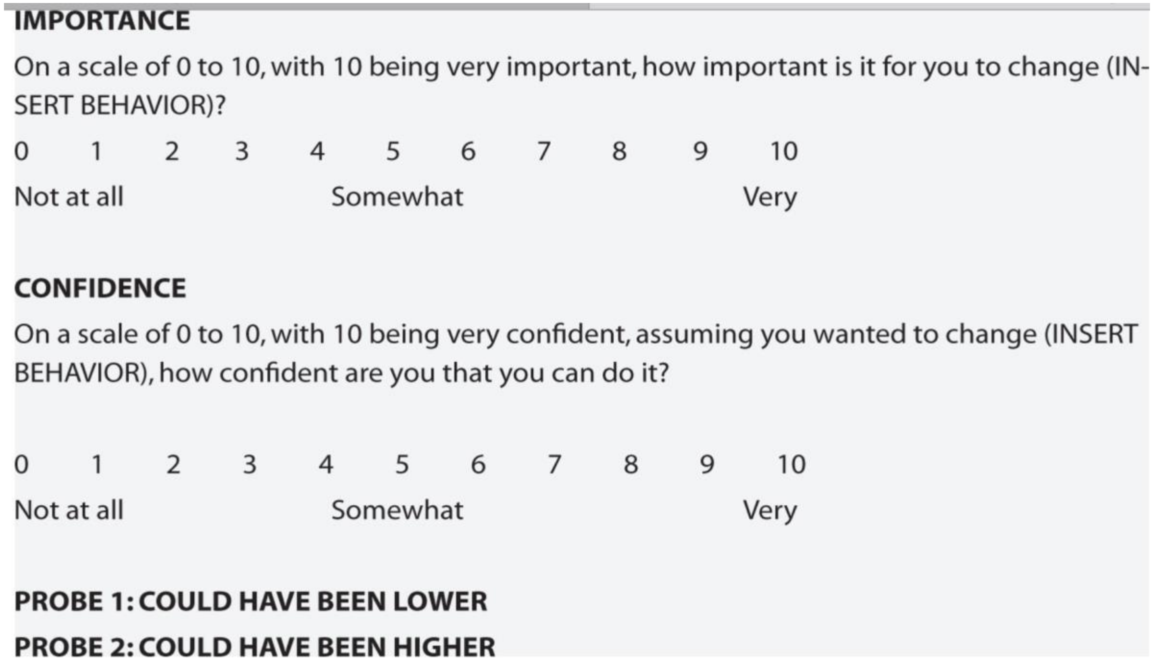
Does the practice utilize a tool to assess and measure patient activation?

Intent: The intent of this metric is to use a standard method to measure a patient's activation level.

Patient Activation

An individual’s overall knowledge, skill, and confidence for self-management.

Studies have shown that activation scores are predictive of outcomes within specific patient groups



IMPORTANCE

On a scale of 0 to 10, with 10 being very important, how important is it for you to change (INSERT BEHAVIOR)?

0 1 2 3 4 5 6 7 8 9 10

Not at all Somewhat Very

CONFIDENCE

On a scale of 0 to 10, with 10 being very confident, assuming you wanted to change (INSERT BEHAVIOR), how confident are you that you can do it?

0 1 2 3 4 5 6 7 8 9 10

Not at all Somewhat Very

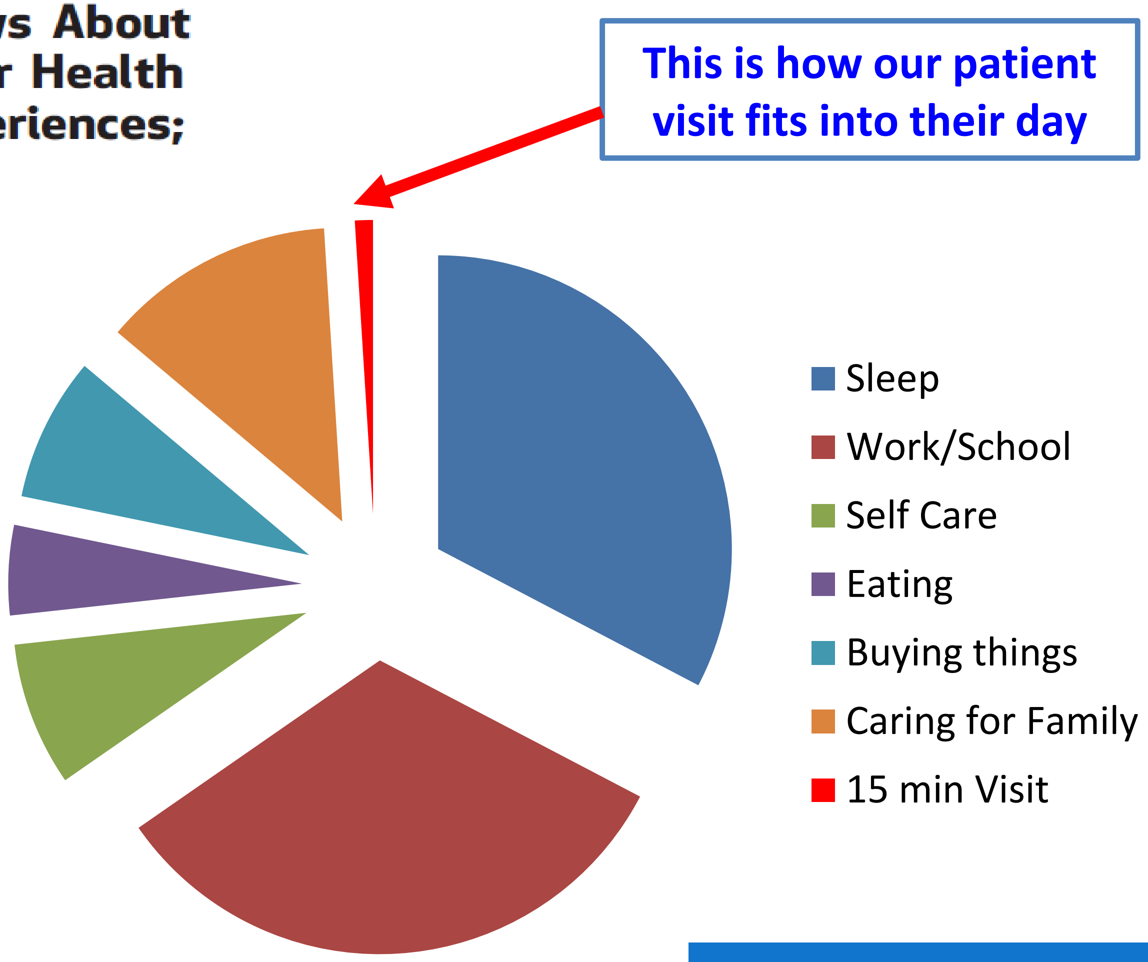
PROBE 1: COULD HAVE BEEN LOWER

PROBE 2: COULD HAVE BEEN HIGHER

Why Care Plans?

By Judith H. Hibbard and Jessica Greene

What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences; Fewer Data On Costs


This is how our patient visit fits into their day

Care Plan Goals

- Understand where patients are in managing their health
- Understand patients' priorities for their health (what matters to you?)
- Create shared goals
- Develop an action plan **WITH** the patient
- Customize care interventions
- Identify and address strength and challenges
- Build skills needed to reach the goal
- Leverage team-based care model

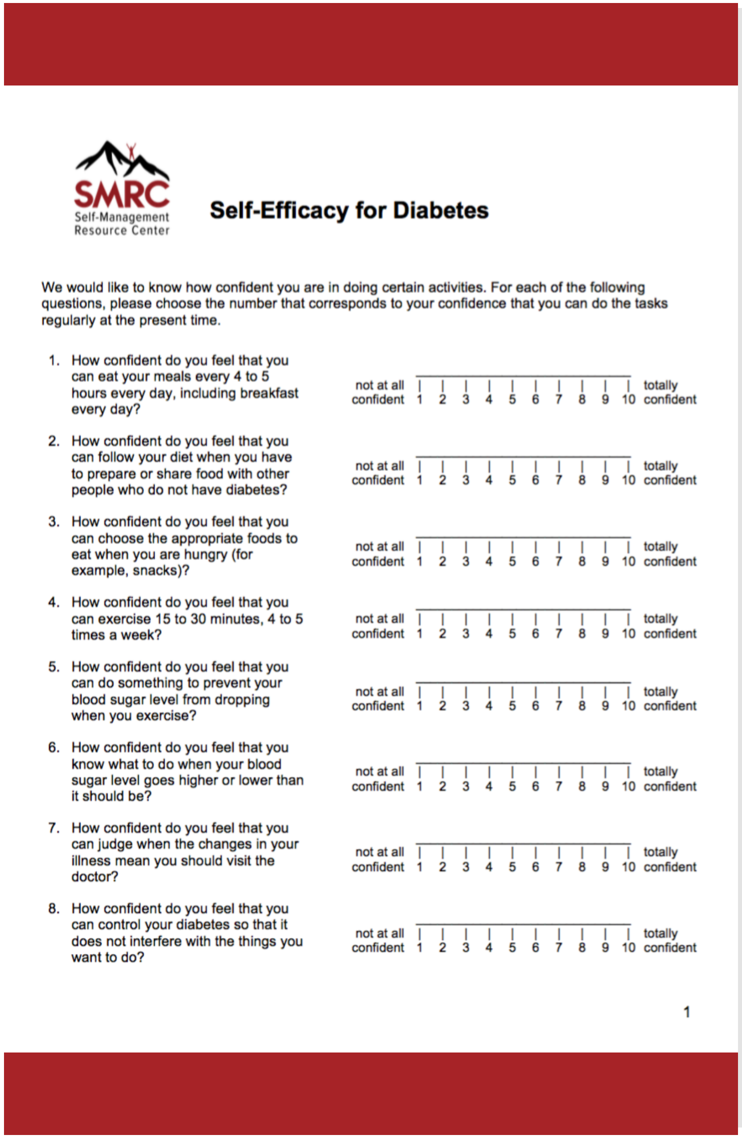
All teams work from the same care plan, for care coordination, shared goals, and communication between teams. Plan is printed and given to patient.

CHA
Cambridge
Health Alliance

HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

Resources

- Stanford Chronic Self-Efficacy Scales
- Patient Health Engagement Scales



SMRC
Self-Management
Resource Center

Self-Efficacy for Diabetes

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
2. How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example, snacks)?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
4. How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
5. How confident do you feel that you can do something to prevent your blood sugar level from dropping when you exercise?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident
8. How confident do you feel that you can control your diabetes so that it does not interfere with the things you want to do?	not at all confident	1	2	3	4	5	6	7	8	9	10	totally confident

1

www.selfmanagementresource.com

Health Literacy

Is a health literacy patient survey being used by the practice (e.g., CAHPS Health Literacy Item Set)?

Intent: The intent of this metric is to ensure that practices are systematic in addressing health literacy issues.

Health Literacy Impacts Engagement

"Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information, and services needed to make appropriate health decisions." NAM report Health Literacy: A Prescription to End Confusion 2004

- Assume most patients may have difficulty comprehending health information and accessing health services
- Implement universal precautions
- Ask patients about their experiences:
  - Were the results of your test easy to understand?
  - Did this provider use medical words you did not understand?

Spotlight on Health Literacy:

Venice Family Clinic

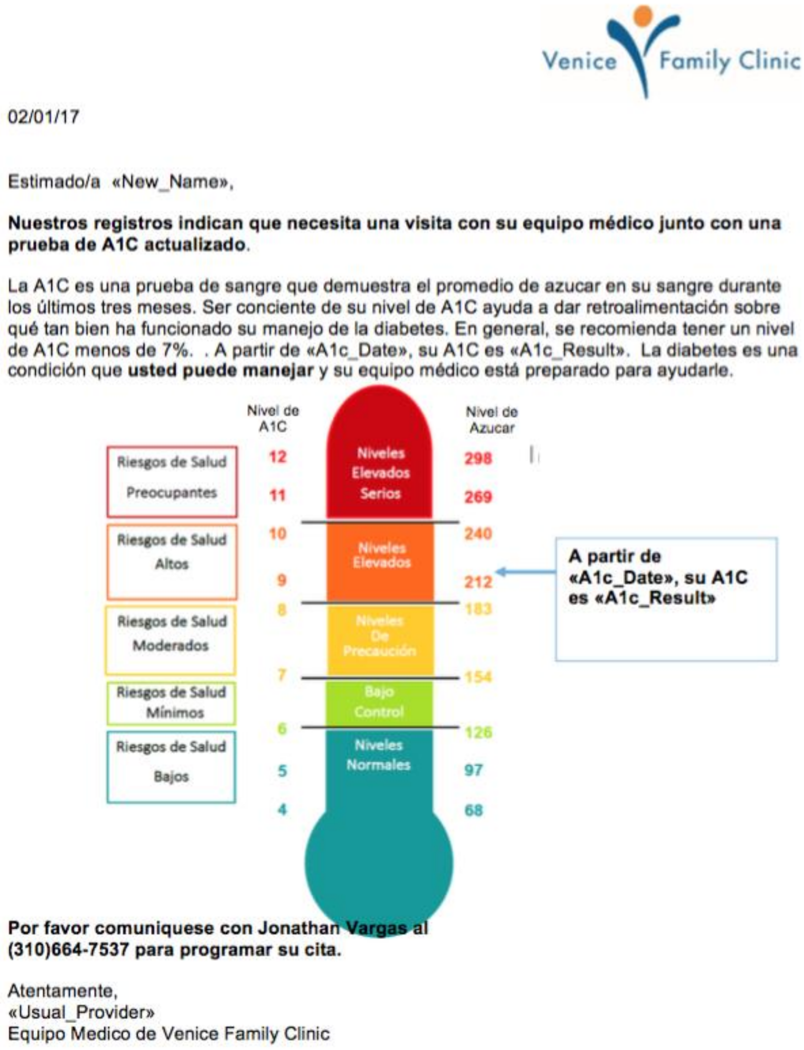
- Improvement Aim: Increase the follow-up appointments with patients whose HgbA1c are above 9
- Response rate to traditional letters or patient portal messages was poor

- Small team of LAPTN QI Advisor, Population Coordinator and Education Department formed
  - Coordinated with diabetes providers re: input and clinical language
  - Analyzed current letter and identified gaps related to best practice for health literacy
  - Utilized http://thewriter.com as a resource

Changes

Venice Family Clinic

- 5-6 grade language
- Shared the patient’s current/last known HA1c
- Used a common “stoplight” visual to place their HA1c in context
- Built on the doctor/patient relationship
- Identified a specific person to call
- Created in both English and Spanish



Venice Family Clinic

02/01/17

Estimado/a «New_Name»,

Nuestros registros indican que necesita una visita con su equipo médico junto con una prueba de A1C actualizado.

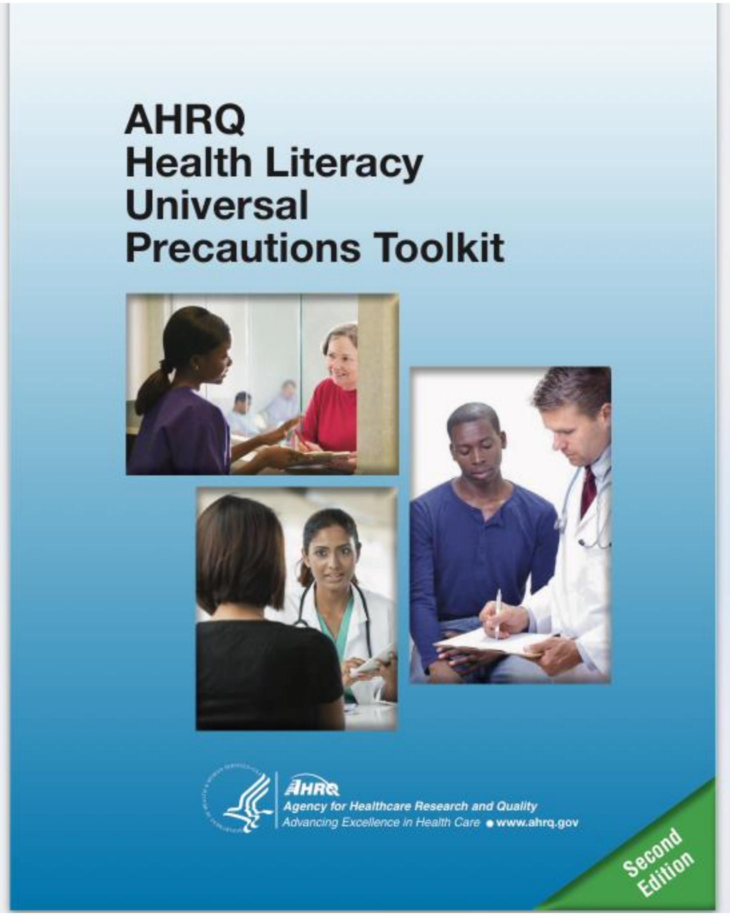
La A1C es una prueba de sangre que demuestra el promedio de azucar en su sangre durante los últimos tres meses. Ser conciente de su nivel de A1C ayuda a dar retroalimentación sobre qué tan bien ha funcionado su manejo de la diabetes. En general, se recomienda tener un nivel de A1C menos de 7%. . A partir de «A1c_Date», su A1C es «A1c_Result». La diabetes es una condición que **usted puede manejar** y su equipo médico está preparado para ayudarle.

A partir de «A1c_Date», su A1C es «A1c_Result»

Por favor comuniquese con Jonathan Vargas al (310)664-7537 para programar su cita.

Atentamente,
«Usual_Provider»
Equipo Medico de Venice Family Clinic

Health Literacy Practices Improves Engagement



AHRQ Health Literacy Universal Precautions Toolkit

AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Second Edition

NC Program on Health Literacy

- Home
- About Health Literacy
- Program Services Provided
- Literacy Assessment Instruments
- Health Communication Aids
- Quick Start Guides
- Teaching Aids
- Presentations
- Health Literacy Universal Precautions Toolkit
- Contact Us

Teaching Aids

The Teach Back Method:

Teach Back Video--a technique for te...

Download movie in Windows Media format here

https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

http://nchealthliteracy.org/teachingaids.html

Medication Management

Does the clinical team work with the patient and family to support their patient/caregiver management of medications?

Intent: The intent of this metric is to ensure that all patients and/or their family are being supported to safely manage their medications.

Patients do not take their medicine as prescribed 50% of the time.

Over 25% of initial prescriptions are never filled.

Inappropriate medication use leads to increased complications and hospitalizations, costing the United States an estimated $100 billion to $290 billion annually.

Viswanathan M, Golin CE, Jones CD, et al. Interventions to improve adherence to self-administered medications for chronic diseases in the United States: a systematic review. Ann Intern Med 2012:157:785–95.

Jimmy, B., & Jose, J. (2011). Patient Medication Adherence: Measures in Daily Practice. Oman Medical Journal, 26(3), 155–159. http://doi.org/10.5001/omj.2011.38

Collaborative Approaches Improve Outcomes

There is significant evidence that a more collaborative medication management strategy that actively engages patients and families results in improved outcomes.*

*Advances Volume 22 No. 4 in Therapy® July/August 2005 Medication Adherence and Persistence: A Comprehensive Review Kem P. Krueger, PharmD, PhD Bruce A. Berger, PhD, RPh Bill Felkey, MS ;
Tran, V.T., et al. Taxonomy of the burden of treatment: A multicountry Web-based qualitative study of patients with chronic conditions. BMC Med, 2015. 13: p. 115.

Building Partnerships for Medication Safety

- Develop a blame-free environment and a positive, trusting relationships with patients and families.
- Partner with patients to determine current medication list and management process.
- Motivate patients by building on their successes and positive experiences.
- Address the burden of treatment.
- Tailor the approach to individual patients and their situations.

What direct care PFE opportunities can you imagine?

What are you currently working to improve where patient and family input could be of value?

Previously Suggested Opportunities:

- Work with the Inherited Retinal Disease Clinic Team on specific projects
- Sub-specialty care team care coordination
- Improvement to Post-Surgical Experience
- Work with the Lean Consultant on integration of patient and family voices into the work underway

Questions?

Webinars, Tools, Resources to Strengthen Your PFE Efforts!

Improving Care Through Partnership with Patients, Families & Communities

The **PCPCC's Support & Alignment Network (SAN)** provides technical assistance to practice improvement teams to foster partnerships with patients, family caregivers, and community-based organizations to achieve common goals of improved care, better health, and reduced costs.

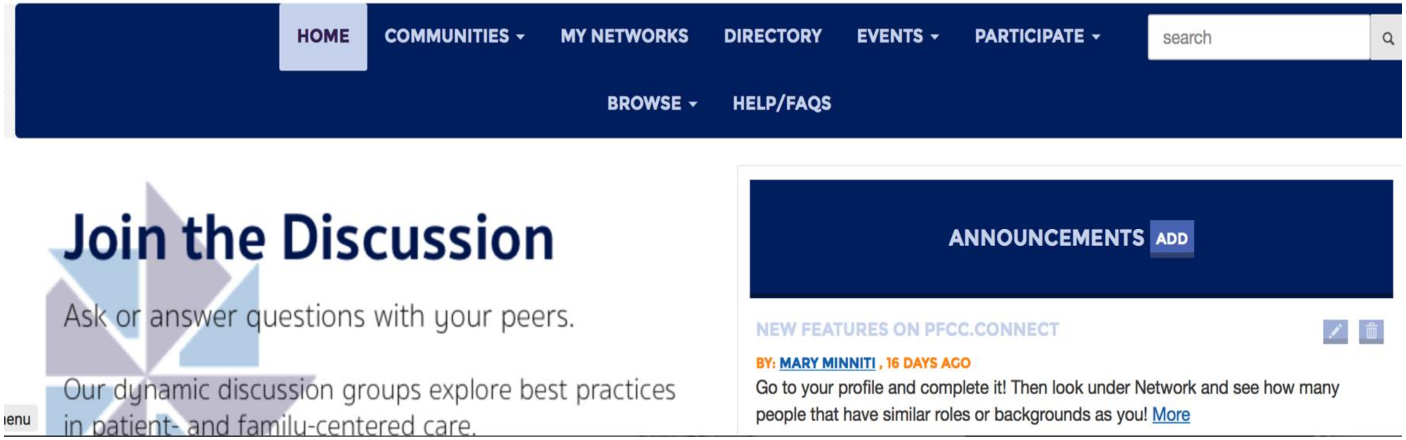
Our work is supported by the Centers for Medicare and Medicaid Services (CMS), through the Transforming Clinical Practice Initiative (TCPI). This four-year initiative (2015-2019) is designed to assist more than 140,000 clinicians achieve large-scale health transformation. Learn More

https://www.pcpcc.org/tcpi

A free on-line learning community dedicated to partnerships with patients and families to improve and transform care across all settings.

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

PFCC.Connect



Join the Discussion

Ask or answer questions with your peers.

Our dynamic discussion groups explore best practices in patient- and family-centered care.

NEW FEATURES ON PFCC.CONNECT

BY: MARY MINNITI , 16 DAYS AGO

Go to your profile and complete it! Then look under Network and see how many people that have similar roles or backgrounds as you! More

http://pfcc.connect.ipfcc.org/home

THANK YOU!

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

www.ipfcc.org

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