Patients and Families as Partners in Care, Quality Improvement and Delivery Transformation

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Patient-Centered Primary Care Collaborative
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national partnership for women & families

About Us

- ***National Partnership for Women & Families***
  - National, non-profit, consumer organization with more than 40 years of experience working on issues important to women and families.
  - Diverse health care portfolio, including:
    - Patient and Family Engagement/Patient and Family Partnerships
    - Quality Measurement and Public Reporting
    - Health Information Technology
  - Multiple health-focused coalitions comprised of consumer, patient, and labor organizations working at national, state and local levels.

Influencing Policy to Advance Patient & Family Engagement/Partnerships

- **Affordable Care Act –** statute, regulations, program requirements
  - Patient-and family-centered criteria
  - Patient and family engagement/partnerships
  - Patient experience
  - Consumer representation in governance
  - Quality measures

Implementation Efforts To Advance Partnerships

- **Ambulatory Practices**
  - Comprehensive Primary Care Initiative (CPC)
    - 500 practices in 7 regions
- **Hospitals**
  - Partnership for Patients (PfP)
    - Nearly 4,000 hospitals participating nationwide
- **Accountable Care Organizations (ACOs)**
  - Pioneer (23 participating; 14 states)
  - MSSP (338 participating)
    - 5 million beneficiaries served

Culture Shift: Patient and Family Partnerships

- **Strategy for achieving Patient- and Family-Centered Care**
- **Working *with* patients and families to identify gaps and generate solutions**
- ***Partnerships* with patients and families are:**
  - Collaborative
  - Meaningful
  - Achieve joint goals

Partnership Opportunities

Work with patients and families on:

- Governance and operational issues
- Quality improvement
- Patient safety
- Community outreach and supports
- Care processes and patient flow
- Access and patient portals
- Patient experience
- Patient education tools, care plans
- Shared decision-making tools

….any and all aspects of care design, delivery, and evaluation….

Achieving Success & Testimonials

- **Necessary Attributes :**
  - Strong leadership support
  - Engaged staff, including champions
  - Organizational culture receptive to shared leadership and change
  - Agreement on PFCC vision and priorities
  - Understanding of the value of partnering with patients and families
  - Some initial resources, including a PFCC point-person

*This is quite **wonderful**. I wish we had started this Council earlier." ~San Luis Valley Health*

*"This is the first time we've **worked with** patients and families in this way. It feels good". ~Bleckley Memorial Hospital*

*"We are amazed at the potential our group has to truly **transform** the way we collaborate with our patients to practice medicine here!"~Springfield Health Care Center*

Using Meaningful Quality Information to Transform Our Health Care System

Alison Shippy

Consumer-Purchaser Alliance: Overview

- The Consumer-Purchaser (C-P) Alliance is a **collaboration** of leading consumer, labor, and employer organizations.

- Our mission is to improve the quality and affordability of health care for consumers and purchasers by **advancing a performance-based health system – one that pays for high-value, patient-centered care**
- Some **Key Players:**
  - AARP
  - National Business Coalition on Health
  - Consumers' Union
  - The Leapfrog Group
  - Xerox

Better Measures

- **Assessing performance is meaningful to consumers and purchasers**
  - Fill measure gaps in targeted areas: patient-reported outcomes, cost, and maternity
  - Improve access to data to support performance measurement
  - Consumer and purchaser voice influential in measurement enterprise
  - Garner input on assessing health care value beyond discrete measures of performance
  - Prioritized measure gaps reflect consumer and purchaser priorities
  - New measures for implementation are identified

Better Use of Measures

- **Purchasing significantly rewards high value care and discourages low value care**
  - Influence federal strategies on:
    - alternatives to FFS payment
    - new models of care
    - hospital value-based purchasing
    - physician value-based purchasing
  - Influence committees and workgroups to include meaningful and useful measures in its recommendations to federal partners, which reflect consumer and purchaser consensus on key policy positions

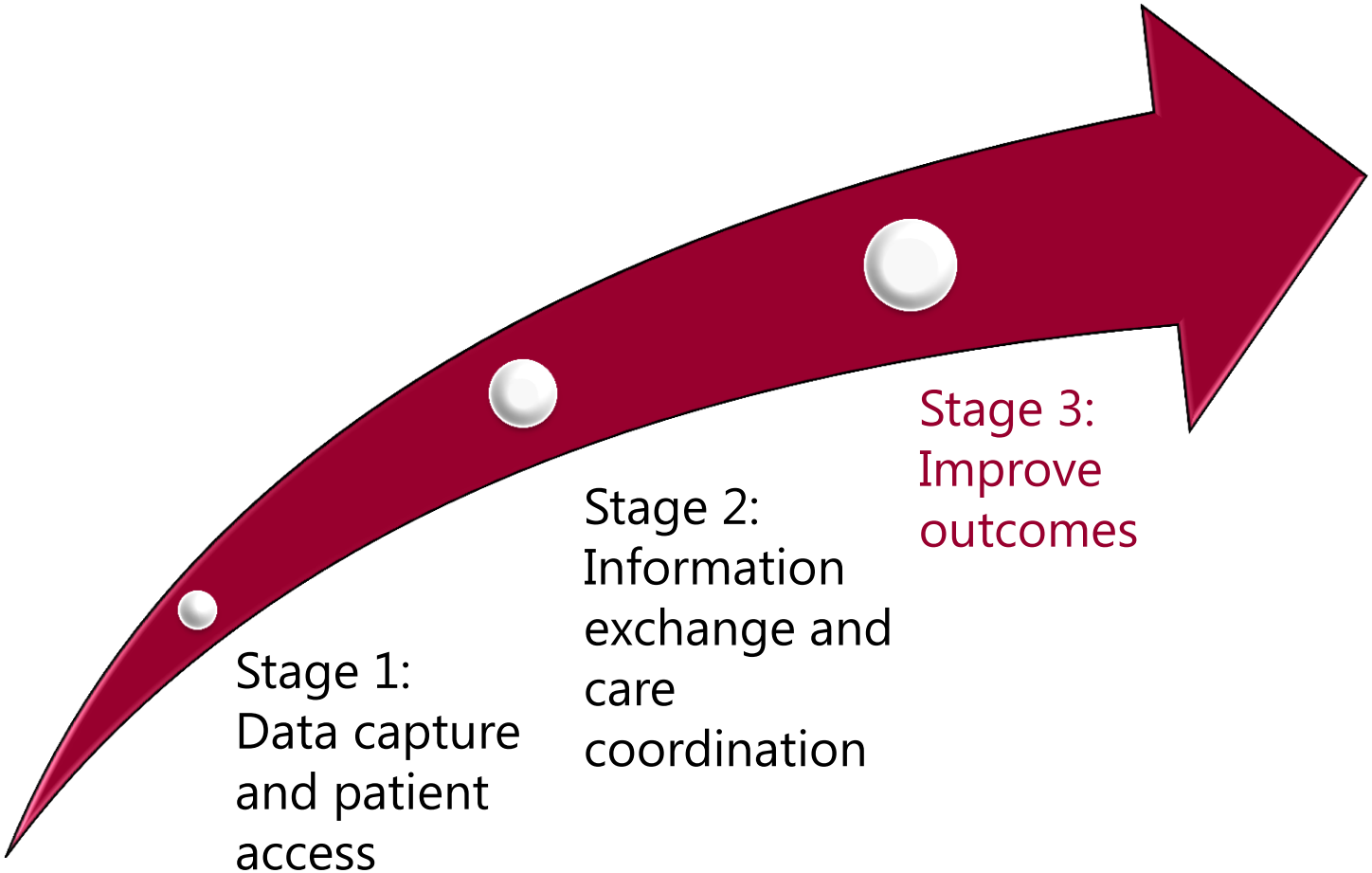
Leveraging Health IT for Care Delivery Transformation

Mark Savage

The HITECH Act of 2009

- **The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009**
  - Part of the American Recovery and Reinvestment Act of 2009, the federal stimulus bill
  - **Builds the backbone and infrastructure of delivery reform, payment reform, quality reform across America**
  - Authorizes an estimated $27 billion over ten years for electronic health information technology and exchange
  - Only Medicare and Medicaid providers are eligible, leveraging the federal role as largest payor of health care through Medicare and Medicaid
  - Congress's stated goal: **By 2014, doctors and hospitals use an electronic health record for every person in the United States**

What is Meaningful Use?



Examples of Meaningful Use Stages

Stage 1

- Record patient demographics & vital signs as structured data
- Send prescriptions electronically
- Incorporate lab tests as structured data
- Provide summary of care for referrals
- Provide patients a visit summary & electronic access to their health data

Stage 2

- Use EHR for lab, medication & radiology orders
- Use electronic clinical decision support to avoid unnecessary or inappropriate care
- Use secure electronic messaging with patients, & reminders
- Ensure that patients can view online, download & transmit their data to others

Stage 3 (draft)

- Use clinical decision support more robustly for preventive care, medications & chronic disease management
- Ensure that patients can upload their health data & request amendments to their records
- Provide educational materials in a language other than English
- Summary of care for transfers may include patient's goals, caregiver

Example 1: Transformation to Patient Online Access to Health Information

In our nationwide survey in 2011:

- **Nearly two thirds (65%) of respondents whose doctors use paper records want online access, and even more Hispanic adults in paper systems (71%) want it**
- **Of respondents/patients with online access to doctors with EHRs, 80 percent use it**
- **Patients with online access were more likely to say:**
  - EHR is useful to them personally for key elements of care (understand condition, keep up with medications, maintain healthy lifestyle, etc.)
  - EHR has a positive impact on quality of care
  - EHRs are useful to their provider (correcting errors records, avoid medical errors, etc.)
  - They trust their provider to protect patient rights

Example 1 (cont.):
View, Download & Transmit (V/D/T)

- **Doctors and hospitals provide patients with the ability to view online, download and transmit electronically their health information within 24 hours (if generated during the course of a patient visit) or within 4 business days (if generated and received outside the visit, e.g. lab results)**
- **Access includes instructions on how patients access their data**
- **Examples of health data:**
  - Current and past problem list
  - Laboratory test results
  - Current medication list and history, medication allergy list and history
  - Vital signs
  - Care plan fields, including goals and instructions, known care team members
  - Family history

Example 2: Transformation to Integrating Patient-Reported Data and Outcomes

- **The Consumer Empowerment Workgroup held a series of hearings in 2013 on patient-generated health data (PGHD)**
- **PGHD are "health-related data—including health history, symptoms, biometric data, treatment history, lifestyle choices, environmental factors and other information—created, recorded, gathered, or inferred by or from patients or their designees (i.e., care partners or those who assist them) to help address a health concern."**
- **PGHD are not new; some are already valued and incorporated into clinical records today (e.g. family history, patient reported outcomes, etc.)**

Example 2 (cont.):
Patient-Generated Health Data (PGHD)

- **EHRs should enable providers to receive, review, respond, and record PGHD**
- **Doctors and hospitals receive provider-requested, electronically-submitted PGHD through either**
  - Structured or semi-structured questionnaires (e.g. screening questionnaires, medication adherence surveys, intake forms, functional status)
  - Secure messaging (email)
  - Menu item
- **Providers should collaborate with patients in implementation—including crafting policies and procedures to ensure that PGHD collection and use work for both providers and patients**

Example 3: Transformation to Language Access Wherever Needed

Women account for 50.8% of population

U.S. **Hispanic population** reached 50.5 million – increase of 43% from 2000

People age 65+ increased 15.1% since 2000; 11,000 baby boomers become eligible for Medicare each day

56 million people live with a **disability**

57 million identify solely as **Black, African-American, American Indian or Native Alaskan, Asian, or Native Hawaiian and Other Pacific Islander**

58 million people ages 5+ speak **language other than English** at home

LGBT individuals comprise 9 million people—3.8% of national population

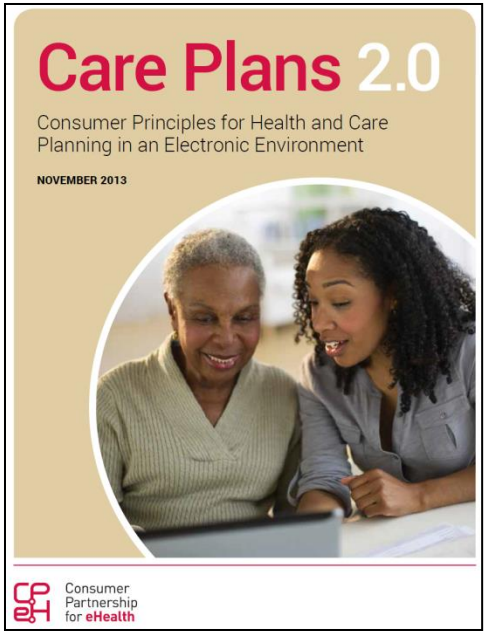
Example 3 (cont.):
Patient Educational Materials

- **Identify patient-specific educational resources and provide them to more than 10 percent of all patients**
- **For non-English-speaking patients, provide in patient's preferred language, if material is publicly available, using the patient's preferred medium (e.g. online, print)**
- **EHRs must be capable of providing materials in at least one non-English language, e.g. Spanish**

Example 4: Transformation to Patient- & Family-Centered Health and Care Planning

What Consumers Want:
Care Plans 2.0

- **A multidimensional, person-centered health & care planning process facilitated by a dynamic, electronic platform that connects individuals, their family and other personal caregivers, paid caregivers (such as direct care workers and home health aides), and health care and social service providers, as appropriate.**
- **The care plan supports all members with actionable information to identify and achieve the individual's health and wellness goals.**



Example 4 (cont.):
Summary of Care for Transfers of Care

- **Doctors and hospitals that are referring patients to another setting or provider of care must provide a summary of care record for more than 50 percent of transfers, electronically for more than 10 percent of transfers.**
- **Summary of care may include (at provider's discretion):**
  - Overarching **patient goals** and/or problem-specific goals
  - Information about known care team (including **designated caregivers**)
  - **Patient instructions**
- **Types of transitions:**
  - Transfers from one site of care to another, e.g. primary care physician, hospital, skilled nursing facility, home, etc.
  - Referral or consultation, e.g. primary care physician to specialist, skilled nursing facility to emergency department

For more information

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