Patient-Centered
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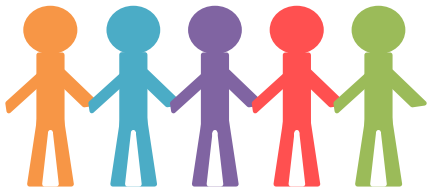
Activating Patient Engagement in Care Delivery

Performance Metrics that Guide Patient-Centered Care (Part 1)

PCPCC Support & Alignment Network
Cambridge Health Alliance

March 22, 2017



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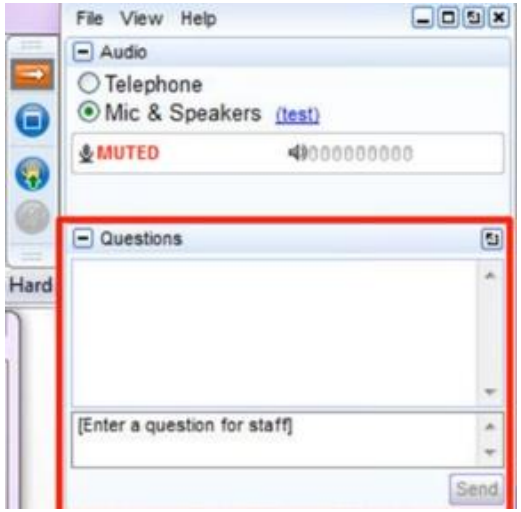
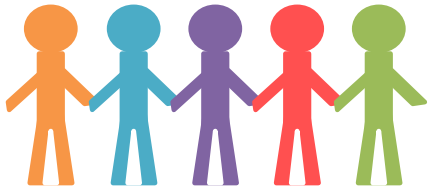
Housekeeping Items



We encourage you to participate in today's presentation!

Please type in your questions or comments into the Question pane in the GoToWebinar control panel.



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Welcome & Acknowledgements

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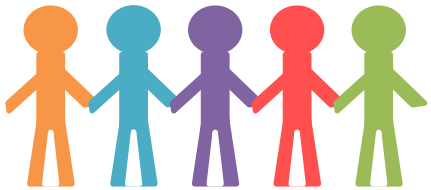
Objectives

- Describe three Transforming Clinical Practice (TCP*i*) performance metrics on patient and family engagement (PFE)
- Share one health care system's story about their integration of patient and family engagement into operations and their results
- Explore resources available to support PFE practices to implement a robust PFE direct care strategy



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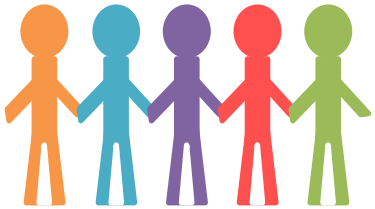
Affordable Care Act

TCP*i* - Transforming Clinical Practice Initiative

- Promote broad payment and practice reform in primary care and specialty care.
- Promote care coordination between providers of services and suppliers.
- Establish community-based health teams to support chronic care management.
- Promote improved quality and reduced cost by developing a collaborative of institutions that support practice transformation.



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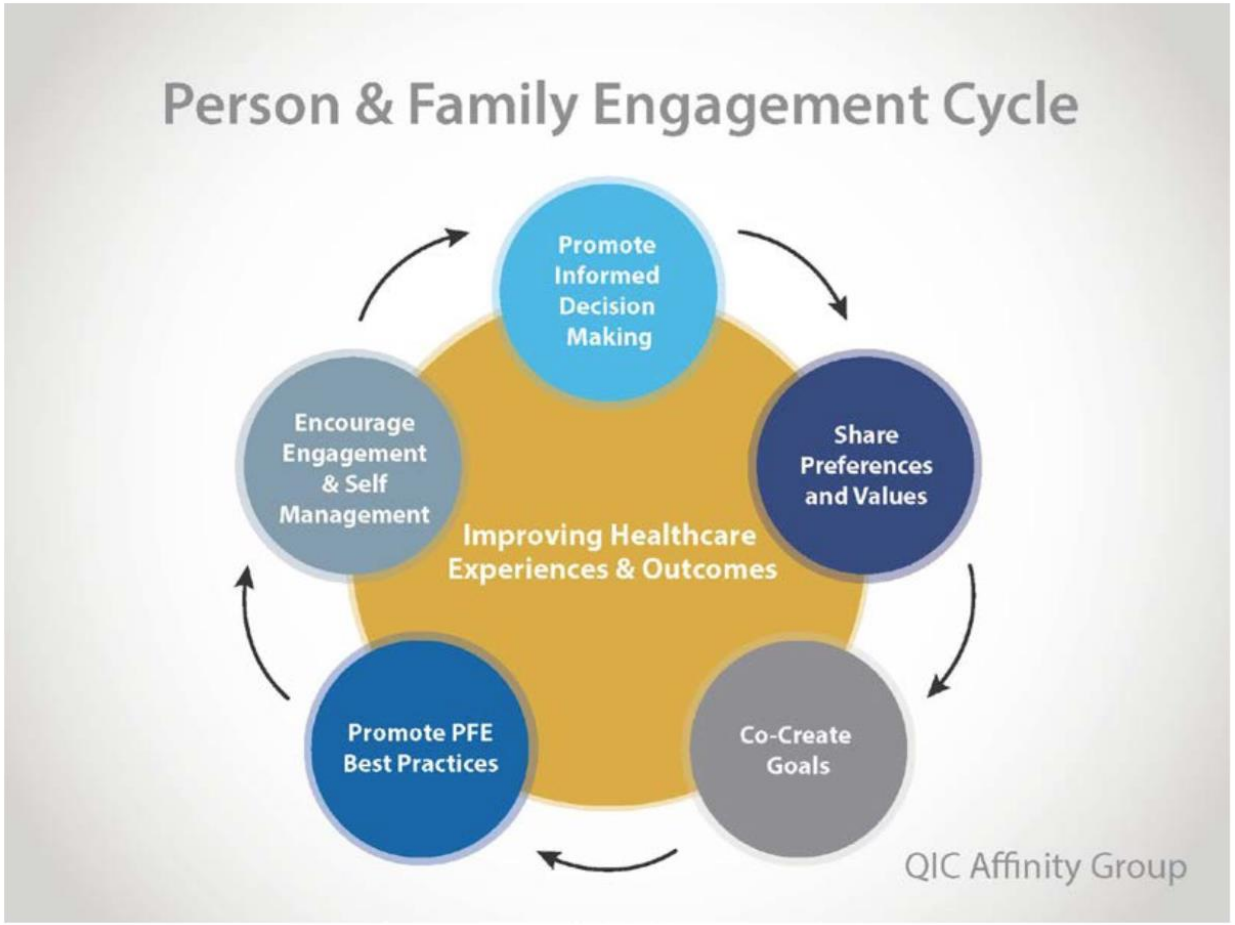
CMS

A Strategic Framework



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

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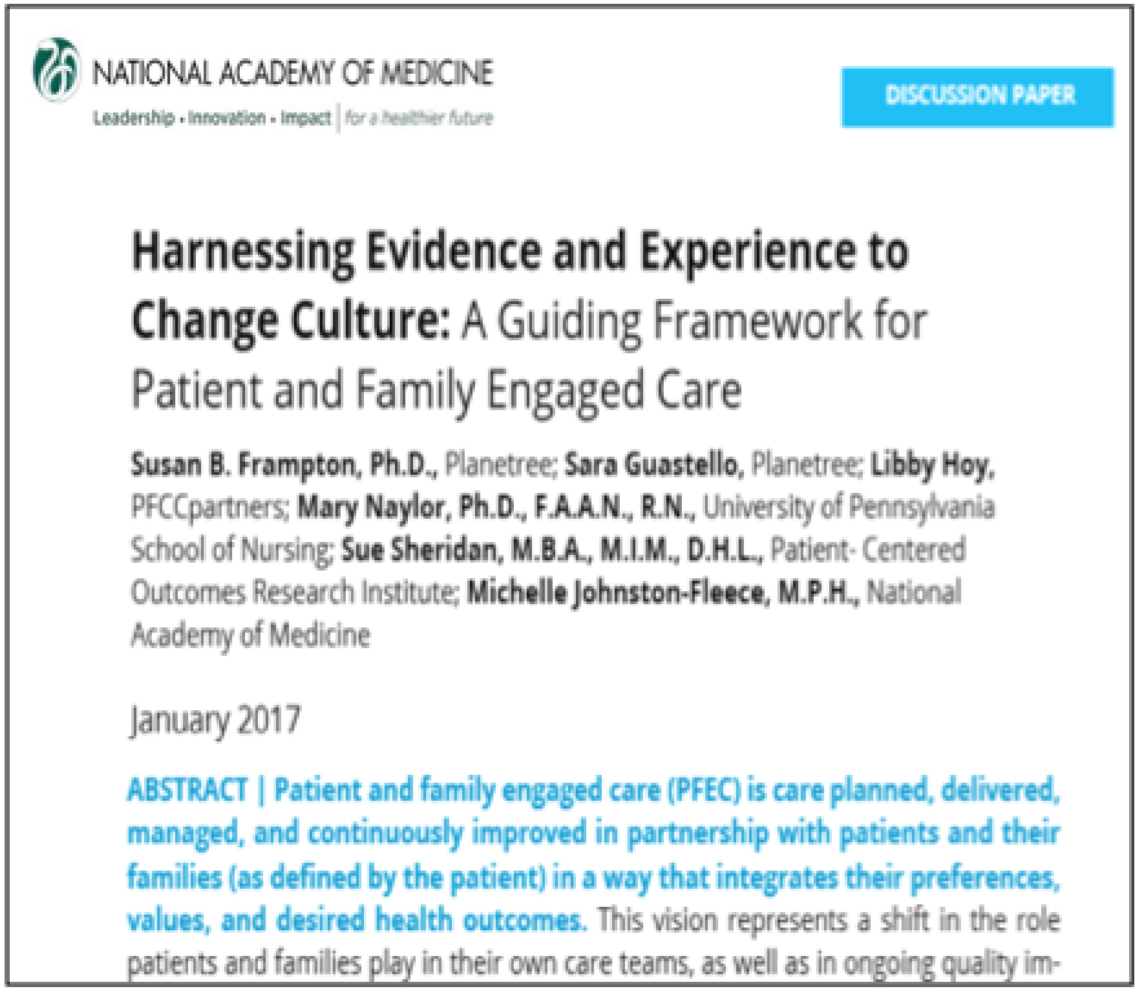
Recent White Paper – Extensive Evidence on PFE



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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-

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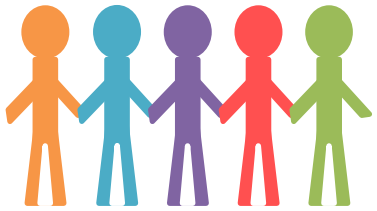
Compelling Evidence

Better culture, care, health and costs:

- 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



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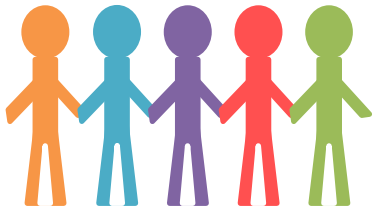
PFE is a Primary Driver in TCPI!

- Quality Payment Program
  - Quality Measures (60% of MIPS score)
    - Patient satisfaction
    - Medication management
  - Advancing Care Information (25% of MIPS score)
    - Patient portals, Summary of Care, e-Prescribing, patient-specific health education
  - Improvement Activities (15% of score)
    - Medicaid patient engagement
    - Patient and family engagement in QI
    - TCPI participation



Are You Ready?

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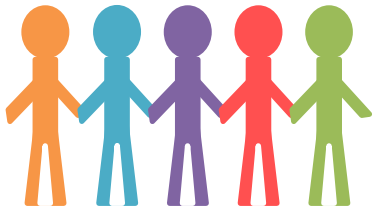
PFE PERFORMANCE METRICS

TCPi | Transforming Clinical Practice Initiative



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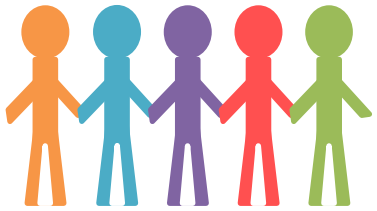
Metric Selection

- Patient Family Engagement Advisory Council launched January 2016
- Created a framework for measuring PFE performance
- Prioritized six metrics to measure across all practices

- Diverse membership:
- Patient and family advocates
- PFE experts
- Patient advocacy organizations
- Person/Family/Community Networks
- Healthcare Clinicians



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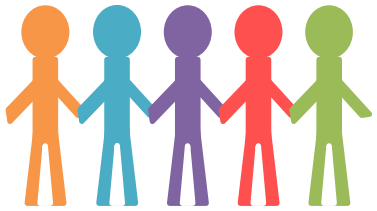
Establishing PFE Baseline & Ongoing Measurement

- Baseline:
  - Established in April/May 2017
  - Collected by Practice Transformation Networks directly from each practice
- Ongoing Measurement:
  - Beginning in June 2017 on 6 month cycle
  - PFE Metric Questions embedded in the PAT



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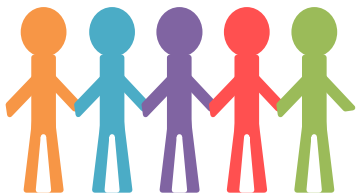
Person and Family Engagement

Point of Care	• E-tool Use • **Shared Decision Making**
Policy and Procedure	• **Patient Activation** • **Health Literacy Survey** • Medication Management
Governance	• Support for Patient and Family Voices



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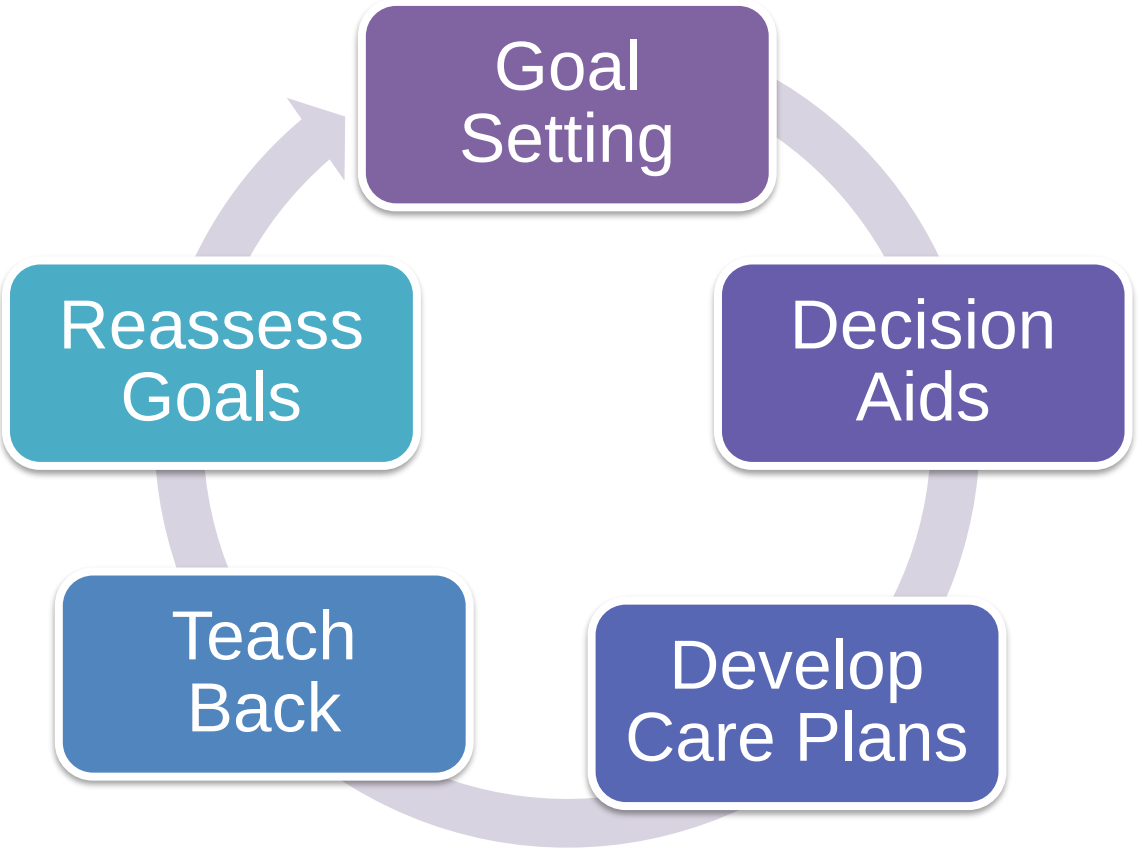
Shared Decision-Making & Self-Management



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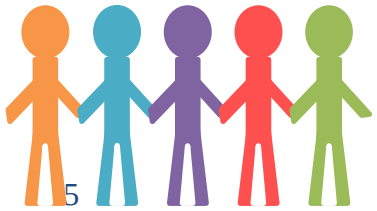
Shared Decision-Making

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.



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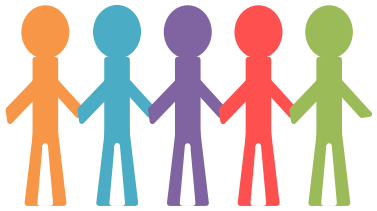
Effective Engagement at the Clinical Encounter

Studies indicate that more engaged patients achieve higher levels of quality and safer care with ***fewer errors and safety concern***….Patient engagement also ***improves chronic disease self-management***, thus ***reducing the overall cost*** burden such as ***decreasing hospital readmissions***, etc.

Scott, Richard, "Patient Engagement Boosts Safety, Quality & Patient Self-Management." Insight On-Healthcare. Nov. 21, 2014.



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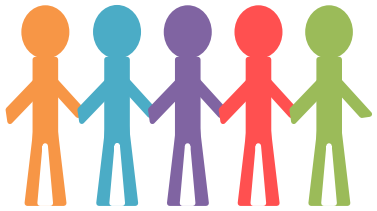
Patient Activation

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 reflects "an individual's overall knowledge, skill, and confidence for self- management".



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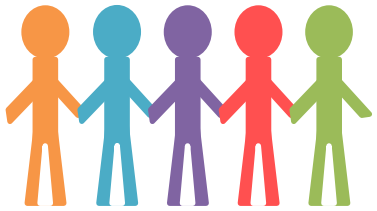
Activation

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

Individualizing care based on patient activation results in better outcomes, lower costs, and encourages an individual's engagement in managing their health and health care.

Hibbard JH, Greene J, Tusler. Improving the outcomes of disease- management by tailoring care to the patient's level of activation. American Journal of Managed Care. 2009;15:353-60.



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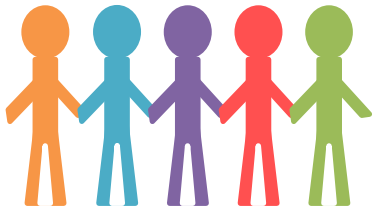
Health Literacy Survey

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.



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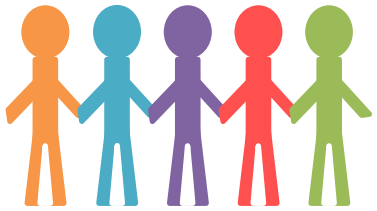
Communicating Via Decision Aids

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.



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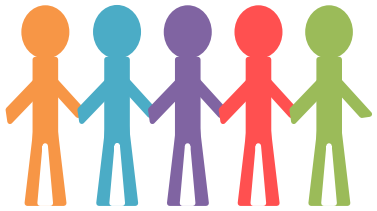
The Story of Partnership



Functional, Patient-Centered Care in the Safety Net....with Care Plans?

Amberly Ticotsky

Ziva Mann

March 22, 2017

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- Academic public health safety net system outside of Boston
- 2 hospitals, 12 community centers, 7 cities
- Public Health mandate
  - 180,000+ primary care visits for 120,000 patients
  - Largely public payer mix – 82%,almost all Medicaid
  - >50% of patients speak a language other than English
  - >3,000 employees, 18 labor unions

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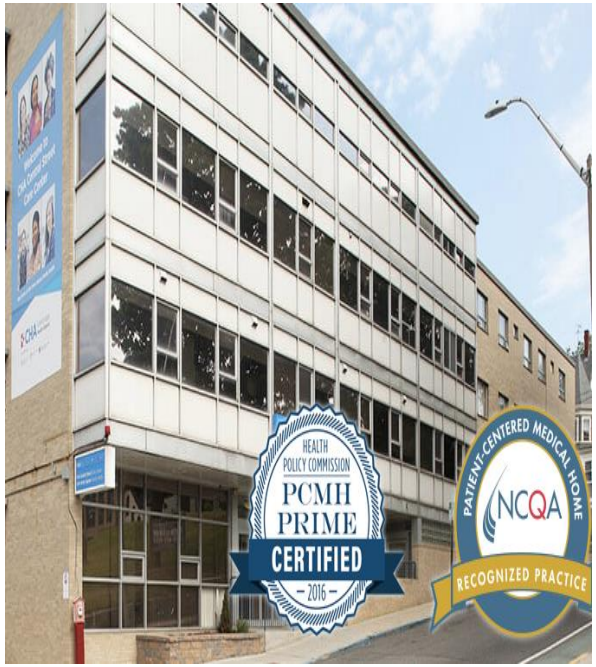
Union Square Family Health

- Participated in three collaboratives to shape cutting edge PCMH transformation
- Robert Wood Johnson designation of one of the top 30 Primary Care practices in the US
- Featured as a model practice by CMS in the TCPi initiative
- Featured by WSJ for team-based care
- Level 3 PCMH Designation
- Full spectrum Family Medicine Care
- 23,000 patient visits per year, 80 percent with public or no insurance
- 40% Brazilian, 20% Spanish from Latin America, 8% Haitian Creole, sizable Hindi, Gujarati, Punjabi and Nepali populations



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THE WALL STREET JOURNAL
THE INFORMED PATIENT
The Doctor's Team Will See You Now

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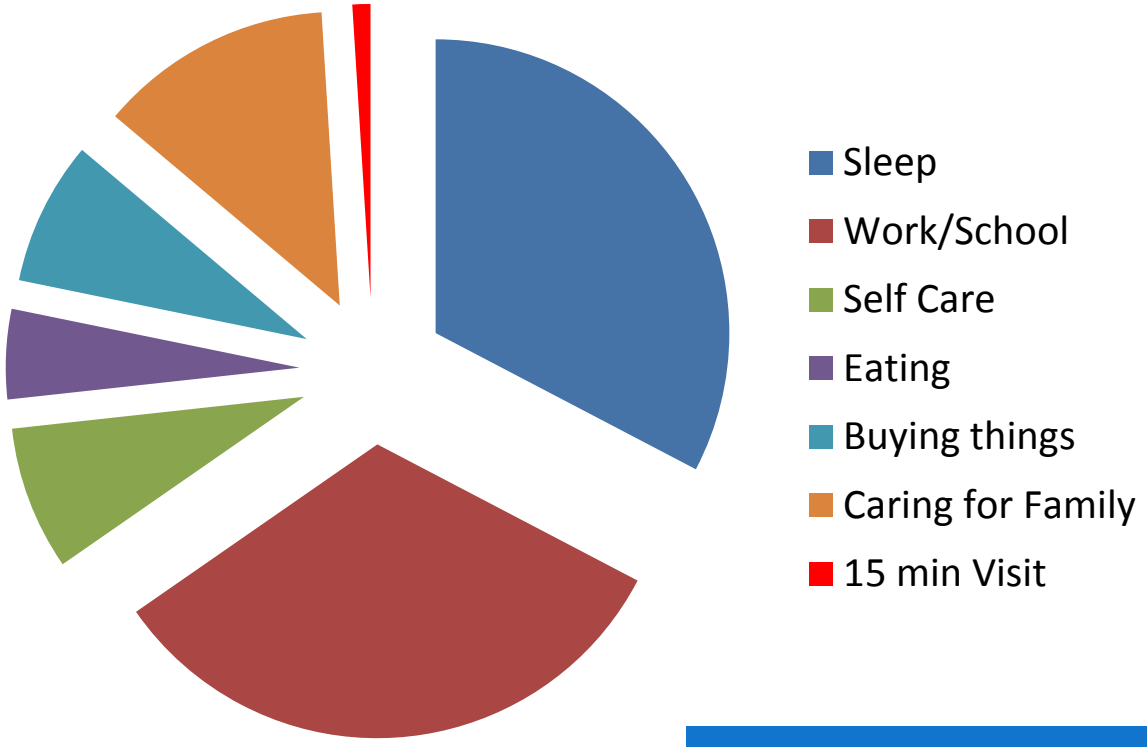
Why Care Plans?

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



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I already have a plan for them.

A Care Plan is

We're already being asked to do too much in a short visit.

What if their goal doesn't have anything to do with getting their diabetes under control?

I don't have time for this.

I'm responsible.
What if this doesn't work?

Patients don't know how to set goals.

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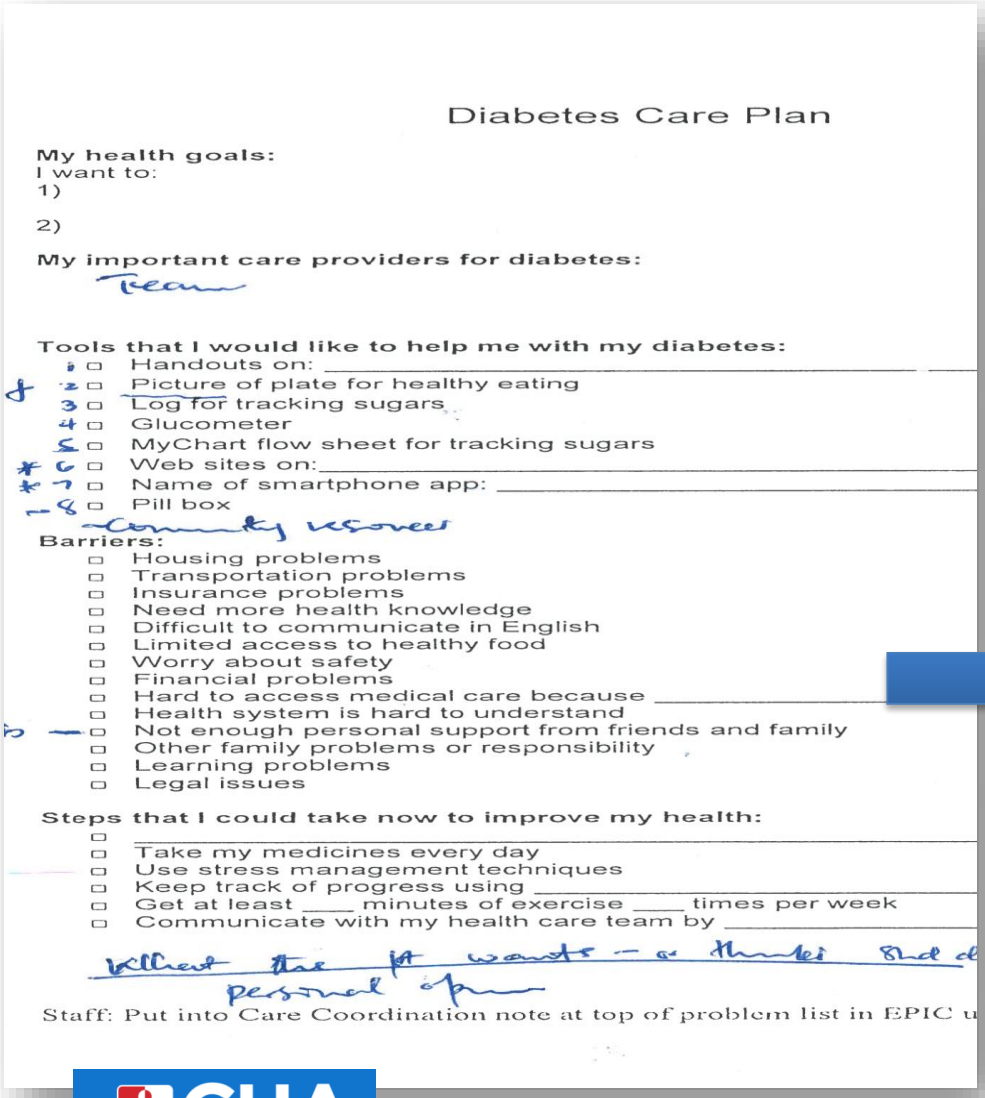
Growing a Care Plan



Diabetes Care Plan

My health goals:
I want to:
1)

2)

My important care providers for diabetes:
Team

Tools that I would like to help me with my diabetes:
- 1 ☐ Handouts on: _____
- 2 ☐ Picture of plate for healthy eating
- 3 ☐ Log for tracking sugars
- 4 ☐ Glucometer
- 5 ☐ MyChart flow sheet for tracking sugars
- 6 ☐ Web sites on: _____
- 7 ☐ Name of smartphone app: _____
- 8 ☐ Pill box

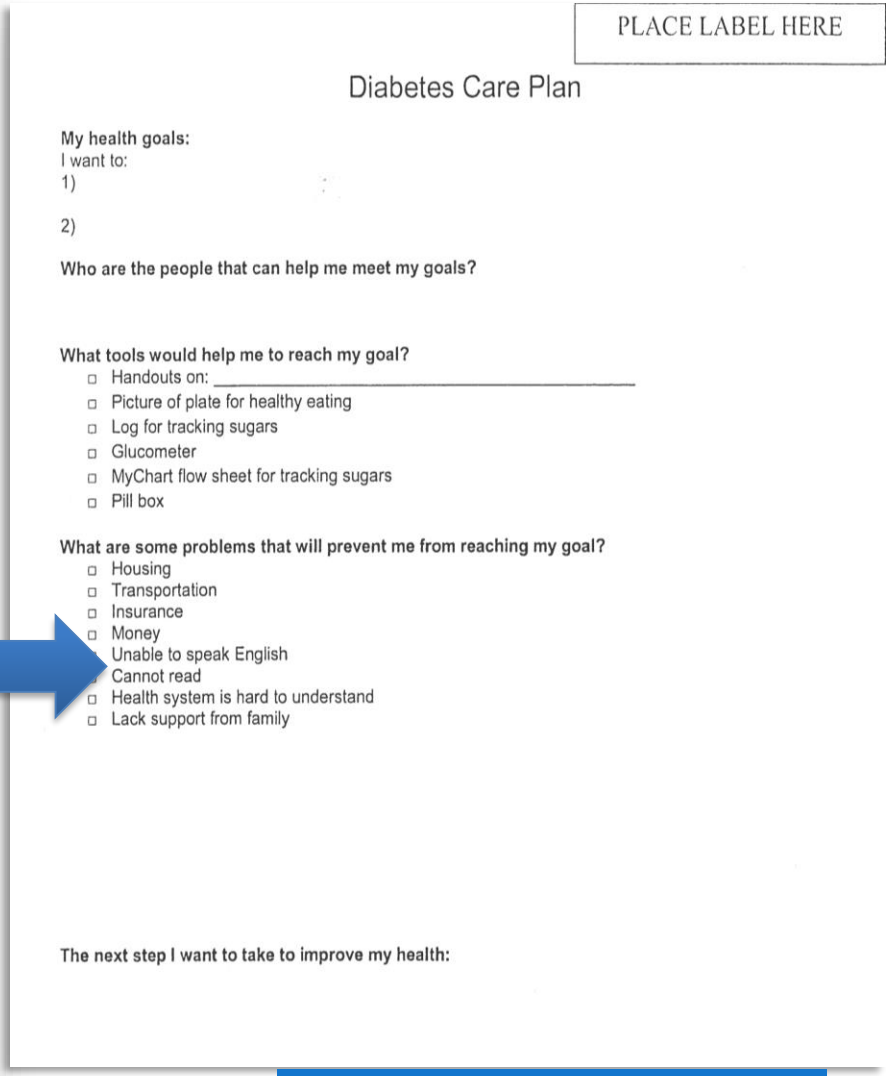
Community resources

Barriers:
- ☐ Housing problems
- ☐ Transportation problems
- ☐ Insurance problems
- ☐ Need more health knowledge
- ☐ Difficult to communicate in English
- ☐ Limited access to healthy food
- ☐ Worry about safety
- ☐ Financial problems
- ☐ Hard to access medical care because _____
- ☐ Health system is hard to understand
- ☐ Not enough personal support from friends and family
- ☐ Other family problems or responsibility
- ☐ Learning problems
- ☐ Legal issues

Steps that I could take now to improve my health:
- ☐ _____
- ☐ Take my medicines every day
- ☐ Use stress management techniques
- ☐ Keep track of progress using _____
- ☐ Get at least ____ minutes of exercise ____ times per week
- ☐ Communicate with my health care team by _____

Reflect the pt wants — or think I find d
personal plan

Staff: Put into Care Coordination note at top of problem list in EPIC u



PLACE LABEL HERE

Diabetes Care Plan

My health goals:
I want to:
1)

2)

Who are the people that can help me meet my goals?

What tools would help me to reach my goal?
- ☐ Handouts on: _____
- ☐ Picture of plate for healthy eating
- ☐ Log for tracking sugars
- ☐ Glucometer
- ☐ MyChart flow sheet for tracking sugars
- ☐ Pill box

What are some problems that will prevent me from reaching my goal?
- ☐ Housing
- ☐ Transportation
- ☐ Insurance
- ☐ Money
- ☐ Unable to speak English
- ☐ Cannot read
- ☐ Health system is hard to understand
- ☐ Lack support from family

The next step I want to take to improve my health:

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Asking the right questions:

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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.

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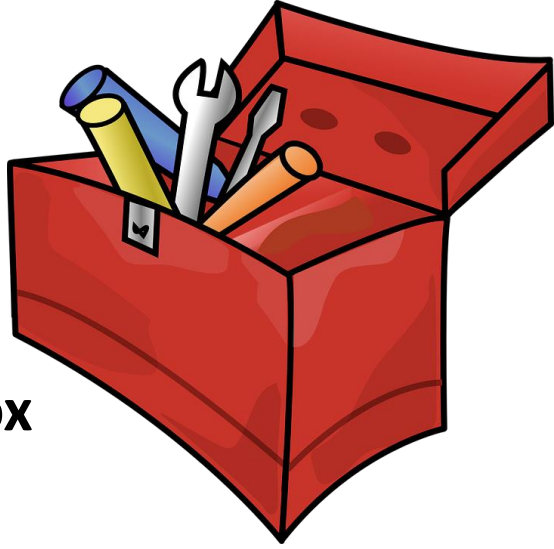
You've Got This!



Built into the care plan

- Patient activation (growing knowledge, skills, confidence)
- Tap into patient's context
- Meet people where they're at
- Skill building
- SMART plans (specific, measurable, achievable, relevant, time-oriented)

In your toolbox

- Motivational Interviewing
- Behavioral Activation
- Relationship building
- Working with vs. to/for
- The extended care team!!

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Care Plan, meet EMR

1. **My goals to improve my health**: ***
2. **My healthcare team's goals**: ***
3. **My strengths and supports to meet my goals**: ***
4. **Challenges to meeting my goals**: *dropdown.*
    - Need more support
    - Housing problems
    - Transportation problems
    - Insurance problems
    - Healthcare providers don't speak my language
    - Legal problems
    - Financial problems
    - Other
5. **My healthcare team**: ***
6. **My Action Plan**: *dropdown.*
    - keep my appointments
    - if I feel worse, I will ***
    - take my medicines every day
    - Keep track of progress using ***
    - Other
1. **My confidence that I can follow my Action Plan**: *1-10*

Care Plans: Patient View

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Living a Healthy Life with Diabetes
My Goals… My Plan

My Health Goals:

1)

2)

Barriers: things could get in the way of me reaching my goals
(for example: money, hard time finding a ride)

My Team: who can help me reach my goals?
(for example: my doctor, family, nutritionist)

Name	Relationship

Tools: which of these things would help me reach my goal?'


Diet Information


Glucometer

Pill Box


Email Your Team

Diabetes Group

MY ACTION PLAN

DATE: _____

_____and _____

ave agreed that to improve my health I will:

. Choose ONE of the activities below:


_____Work on something that's bothering me:


_____Stay more physically active!


_____Take my medications.


_____Improve my food choices.


Reduce my stress.


_____Cut down on smoking.

2. Choose your confidence level:
How sure are you that you can do the action plan? (if < 7, then change plan)

10 VERY SURE

7 SURE

5 SOMEWHAT SURE

0 NOT SURE AT ALL

3. Fill in the details of your activit

What: _____

How much: _____

When: _____

How often: _____

Where: _____

With whom: _____

Start Date: _____

Follow-Up Date:

Best Way to Follow-Up: _____

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Care Plans in Action

- I don't understand how my sugar is not well controlled when I take all my medications.
- Quit smoking, lose weight
- Get off opiates for good
- Could I go back to work, or back to school? apply for disability?
- Strengthen relationship with wife
- I need to sleep at night. I am exhausted.
- Less pain.
- I want to live in a safe situation.

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Impact: Staff

"I love the action plan because it helps patients create realistic, actionable steps toward their goals."

"It allows me to understand where patients are starting from."

"This is a cornerstone of our conversations with patients about depression, because it provides an opportunity to take concrete steps that can have an impact."

"When I sit with a patient to do a care plan, I stop and listen."

"People can focus more on what's important to them, and in their life."

"It's more collaborative: patient and PCP share the work of putting it together, and the patient leads the process."

"Patients are more engaged."

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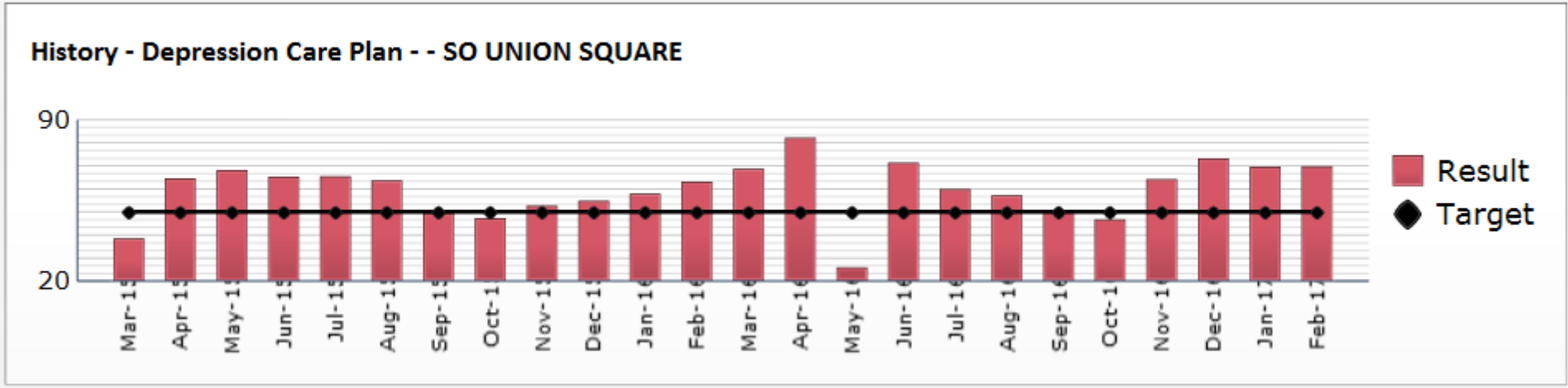
Impact: Patients

- “These people are trying to help me, and I should listen to them.”
- “I love Virginia (PCP)!”
- “I felt like I wasn’t just another patient.”
- “Okay, doc, here’s what we’re going to work on next...”



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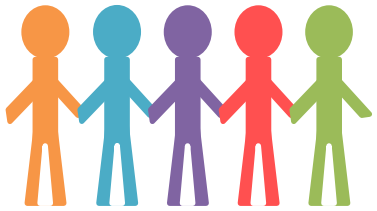
Resources that support implementation of PFE interventions



Patient-Centered Primary Care COLLABORATIVE

AHRQ Shared Decision-Making Resources

https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

Patient-Centered
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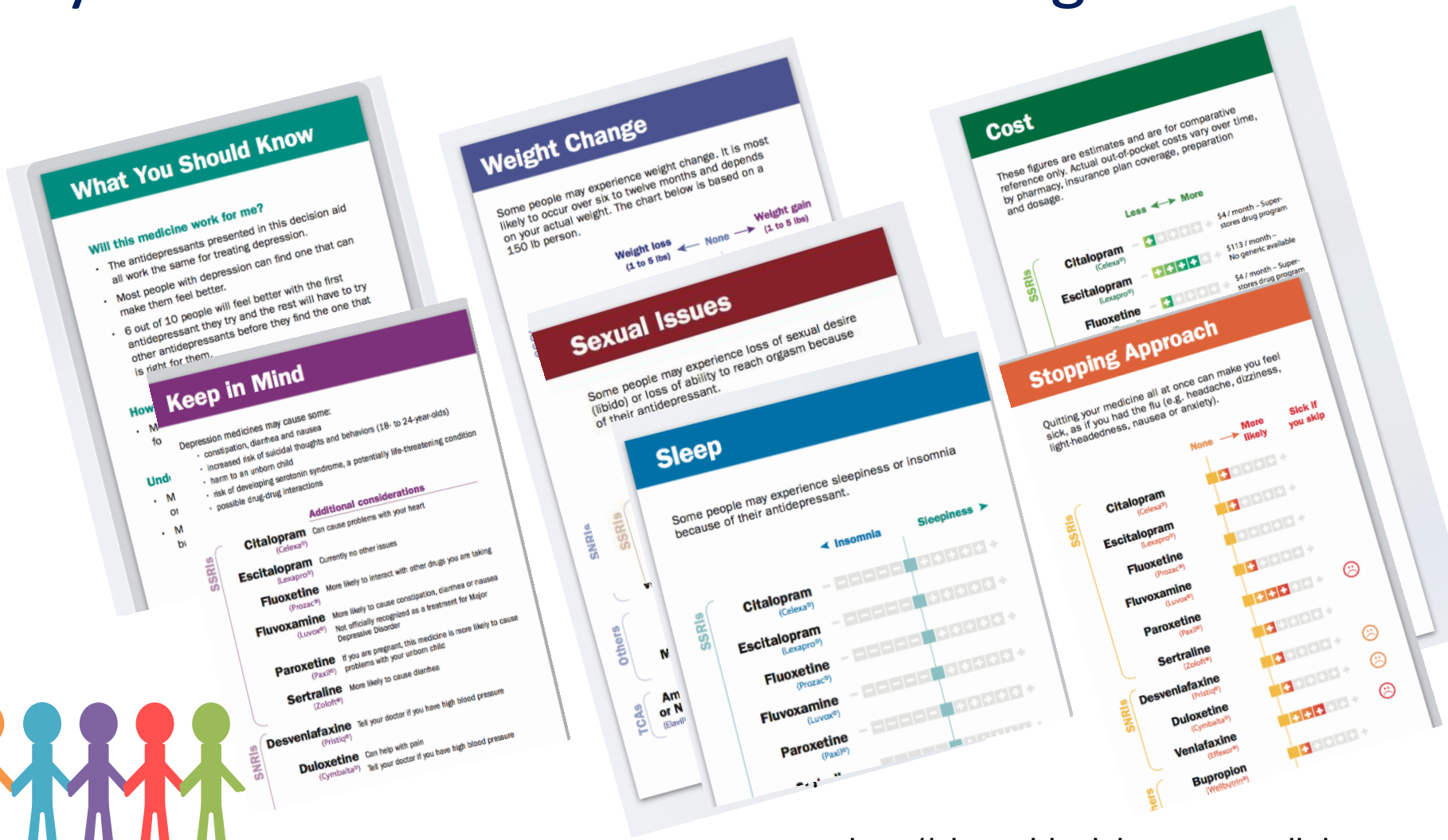
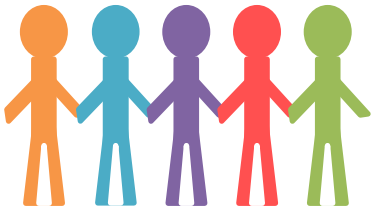
Mayo Clinic Shared Decision-Making Tools



http://shareddecisions.mayoclinic.org

Patient-Centered Primary Care COLLABORATIVE

Decision Aids - Healthwise



http://www.informedmedicaldecisions.org/shareddecisionmaking.aspx

Patient-Centered
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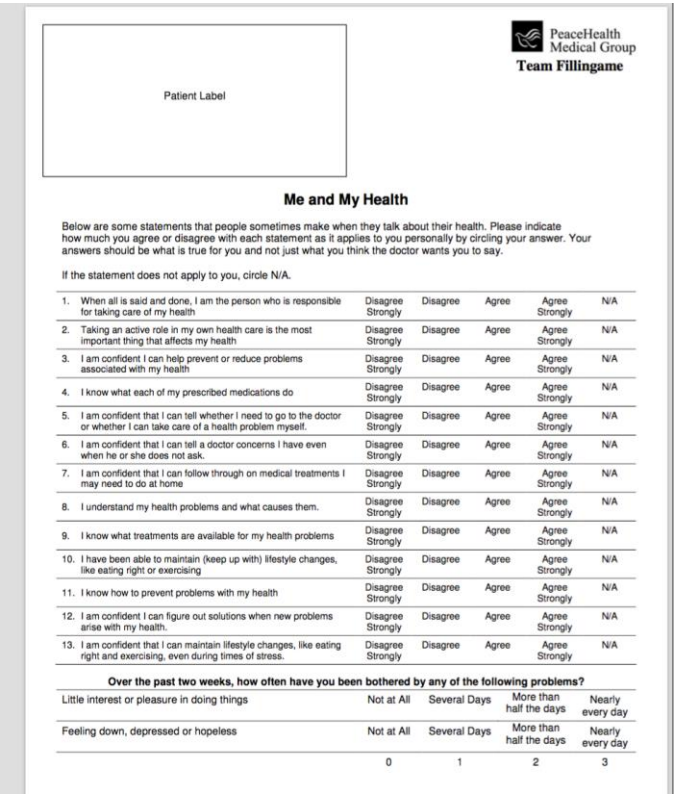
Patient Activation Measure



PeaceHealth Medical Group
Team Fillingame

Patient Label

Me and My Health

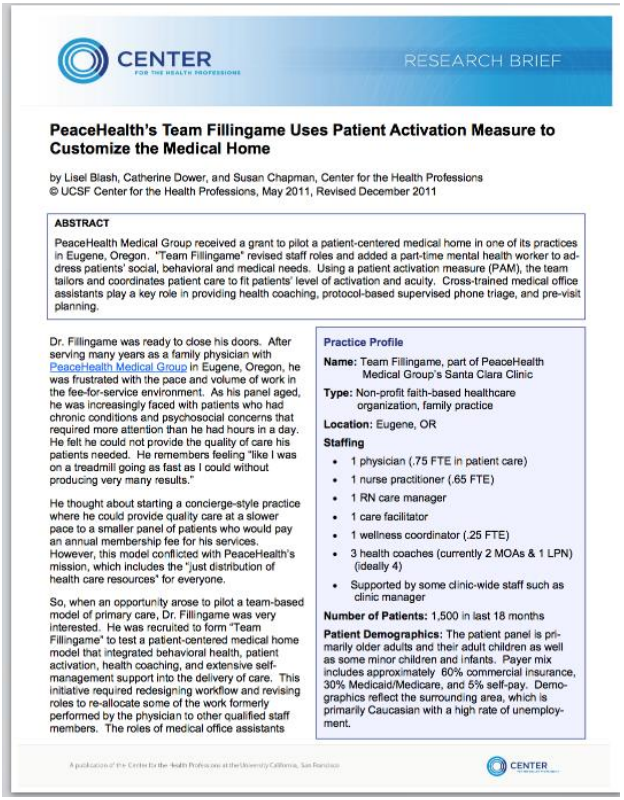
Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say.

If the statement does not apply to you, circle N/A.

1. When all is said and done, I am the person who is responsible for taking care of my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
2. Taking an active role in my own health care is the most important thing that affects my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
3. I am confident I can help prevent or reduce problems associated with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
4. I know what each of my prescribed medications do	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
5. I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
6. I am confident that I can tell a doctor concerns I have even when he or she does not ask.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
7. I am confident that I can follow through on medical treatments I may need to do at home	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
8. I understand my health problems and what causes them.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
9. I know what treatments are available for my health problems	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
10. I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
11. I know how to prevent problems with my health	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
12. I am confident I can figure out solutions when new problems arise with my health.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A
13. I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress.	Disagree Strongly	Disagree	Agree	Agree Strongly	N/A

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at All	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at All	Several Days	More than half the days	Nearly every day
	0	1	2	3



CENTER FOR THE HEALTH PROFESSIONS — RESEARCH BRIEF

PeaceHealth's Team Fillingame Uses Patient Activation Measure to Customize the Medical Home

by Lisel Blash, Catherine Dower, and Susan Chapman, Center for the Health Professions
© UCSF Center for the Health Professions, May 2011, Revised December 2011

ABSTRACT

PeaceHealth Medical Group received a grant to pilot a patient-centered medical home in one of its practices in Eugene, Oregon. "Team Fillingame" revised staff roles and added a part-time mental health worker to address patients' social, behavioral and medical needs. Using a patient activation measure (PAM), the team tailors and coordinates patient care to fit patients' level of activation and acuity. Cross-trained medical office assistants play a key role in providing health coaching, protocol-based supervised phone triage, and pre-visit planning.

Dr. Fillingame was ready to close his doors. After serving many years as a family physician with PeaceHealth Medical Group in Eugene, Oregon, he was frustrated with the pace and volume of work in the fee-for-service environment. As his panel aged, he was increasingly faced with patients who had chronic conditions and psychosocial concerns that required more attention than he had hours in a day. He felt he could not provide the quality of care his patients needed. He remembers feeling "like I was on a treadmill going as fast as I could without producing very many results."

He thought about starting a concierge-style practice where he could provide quality care at a slower pace to a smaller panel of patients who would pay an annual membership fee for his services. However, this model conflicted with PeaceHealth's mission, which includes the "just distribution of health care resources" for everyone.

So, when an opportunity arose to pilot a team-based model of primary care, Dr. Fillingame was very interested. He was recruited to form "Team Fillingame" to test a patient-centered medical home model that integrated behavioral health, patient activation, health coaching, and extensive self-management support into the delivery of care. This initiative required redesigning workflow and revising roles to re-allocate some of the work formerly performed by the physician to other qualified staff members. The roles of medical office assistants

Practice Profile

Name: Team Fillingame, part of PeaceHealth Medical Group's Santa Clara Clinic

Type: Non-profit faith-based healthcare organization, family practice

Location: Eugene, OR

Staffing

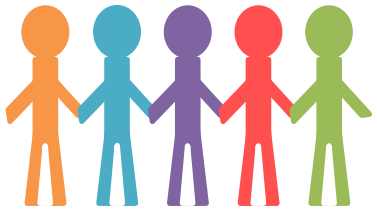
- 1 physician (.75 FTE in patient care)
- 1 nurse practitioner (.65 FTE)
- 1 RN care manager
- 1 care facilitator
- 1 wellness coordinator (.25 FTE)
- 3 health coaches (currently 2 MOAs & 1 LPN) (ideally 4)
- Supported by some clinic-wide staff such as clinic manager

Number of Patients: 1,500 in last 18 months

Patient Demographics: The patient panel is primarily older adults and their adult children as well as some minor children and infants. Payer mix includes approximately 60% commercial insurance, 30% Medicaid/Medicare, and 5% self-pay. Demographics reflect the surrounding area, which is primarily Caucasian with a high rate of unemployment.

A publication of the Center for the Health Professions at the University of California, San Francisco

https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/10.1%202011_05_PeaceHealth%27s_Team%20Fillingame_Uses_Patient_Activation_Measures_to_Customize_the_Medical_Home.pdf

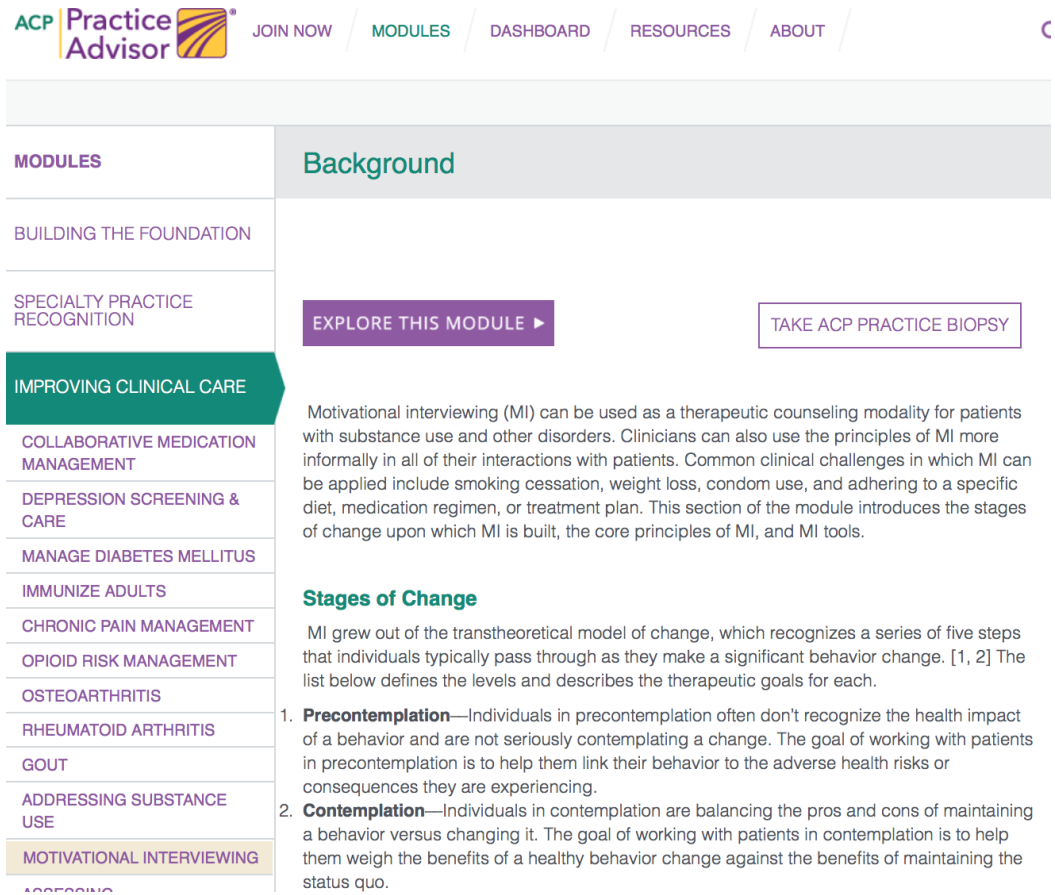


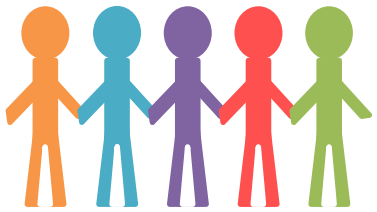
www.insigniahealth.com

Free **access** to the PAM may be available through your local QIN/QIO.

Patient-Centered Primary Care COLLABORATIVE

Patient Activation – Motivational Interviewing





https://practiceadvisor.org/Modules/improving-clinical-care/motivational-interviewing

Patient-Centered Primary Care COLLABORATIVE

Patient Activation - Confidence

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

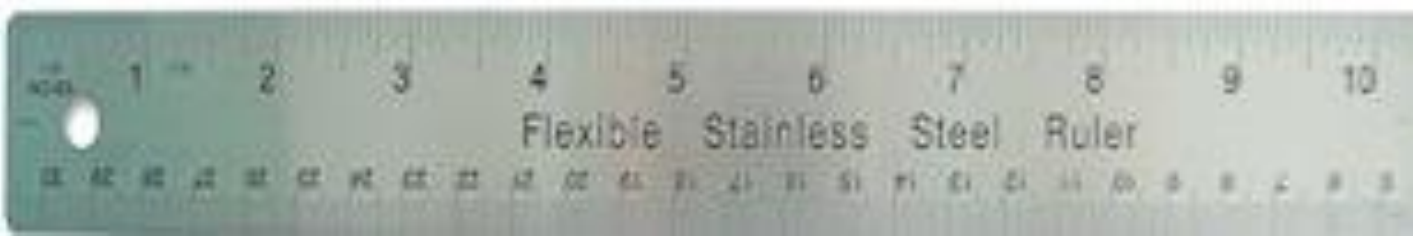
On a scale of 0 to 10, with 10 being very confident, assuming you wanted to change (INSERT BEHAVIOR), how confident are you that you can do it?

0 1 2 3 4 5 6 7 8 9 10

Not at all Somewhat Very

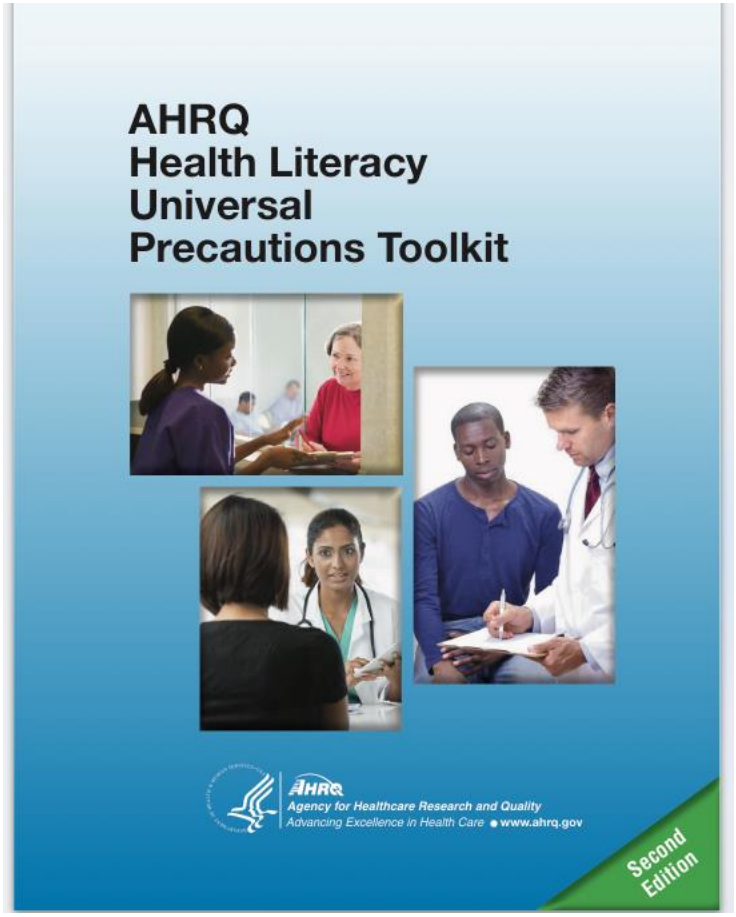
PROBE 1: COULD HAVE BEEN LOWER

PROBE 2: COULD HAVE BEEN HIGHER



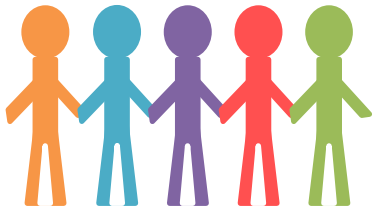
Patient-Centered Primary Care COLLABORATIVE

AHRQ Health Literacy Tools



Quick Start Guide

1	**Watch a short video.** This 6-minute health literacy video was sponsored by the American College of Physicians Foundation and has some vivid examples of why addressing health literacy is so important.	
2	**Pick a tool and try it.** Link to one of these tools and review it. Pick a day and try it out on a few patients.	
	I want to be confident my patients are taking their medicines correctly.	Conduct Brown Bag Medicine Reviews
	I want to be confident that I am speaking clearly to my patients.	Communicate Clearly
	I want to be confident that my patients understand what they need to do regarding their health when they get home.	Use the Teach-Back Method
3	**Assess your results.** How did it go? Do you need to make some adjustments? Do you want to address another statement from the list above and try another tool? Or, you may want to be more systematic and implement "Tools to Start on the Path to Improvement," Tools 1, 2, and 3).	



http://nchealthliteracy.org/teachingaids.html

Patient-Centered Primary Care COLLABORATIVE

Additional Health Literacy Resources

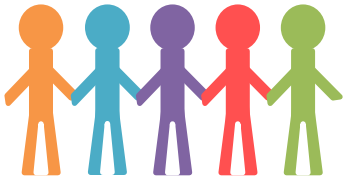
http://nchealthliteracy.org/teachingaids.html

Patient-Centered Primary Care COLLABORATIVE

CAPHS Health Literacy Survey - Clinics

- HL9: Provider gave all the health information patient wanted
- HL10: Provider encouraged patient to discuss health questions or concerns
- HL14: Provider asked patient to describe how patient was going to follow instructions
- HL18: Blood test, x-ray, or other test results were easy to understand
- HL21: Provider gave easy to understand instructions about taking medicines

- Created October 1, 2015
- 31 supplemental questions
- The items address the following five topic areas:
  - Communication with provider
  - Disease self-management
  - Communication about medicines
  - Communication about test results
  - Communication about forms



cahps®

https://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html

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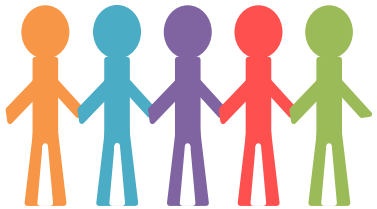
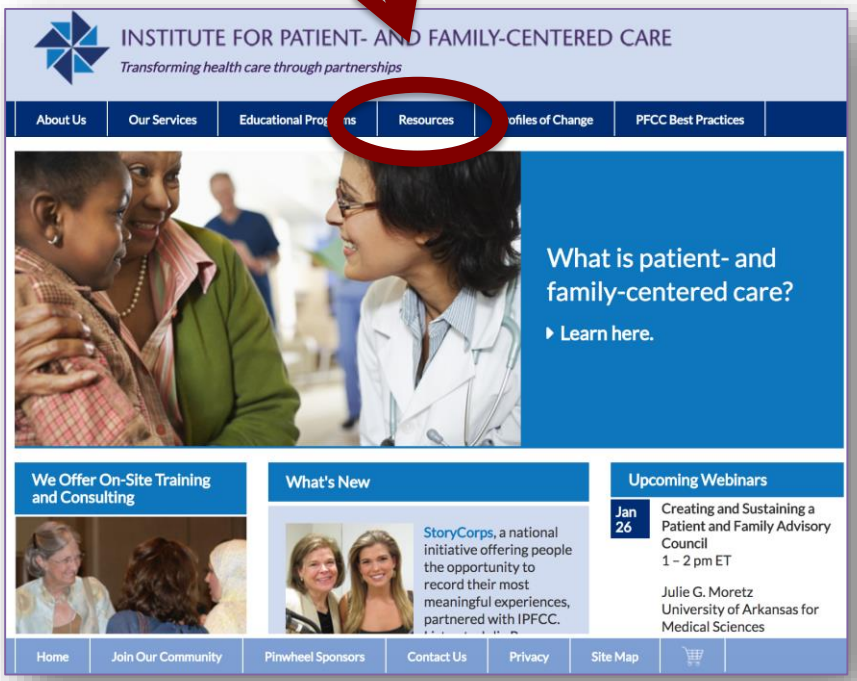
Additional Resources

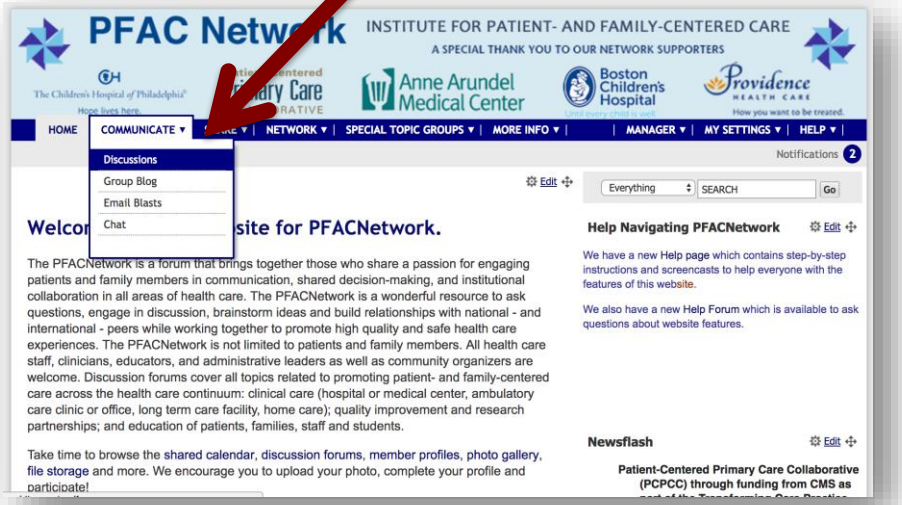


Institute for Patient and Family Centered Care

Resources

Discussion Forums





Join at: pfacnetwork.ipfcc.org

http://www.ipfcc.org/

Patient-Centered Primary Care COLLABORATIVE

https://www.pcpcc.org/tcpi

PCPCC SAN Resources

PCPCC SAN: Improving Care Through Partnership with Patients, Families and Communities

Welcome to the Patient Centered Primary Care Collaborative's Support and Alignment Network (SAN). We are part of the **Transforming Clinical Practice Initiative,** a nationwide program to help clinicians transform the way they practice to improve outcomes, reduce costs, and improve health care quality. Our SAN offers training, technical assistance and coaching to help TCPI clinicians engage individuals, families and communities to improve care.

Why engage patients and families?

Every person has a different perspective on their own health care, influenced by culture, family situation, age, language and a lot of other factors. To be effective, health care has to address the needs of the person, not just some hypothetical 'patient.' Patient or person-centered care means offering health care services to individuals based on their needs, preferences, and circumstances. Person-centered care makes a difference: it makes patients and families feel more welcome, encourages them to participate in their own health as partners, and improves the patient's experience of care.

Why should clinicians care?

The Transforming Clinical Practice Initiative is a nationwide program to help clinicians transform the way they practice to improve outcomes, reduce costs, and improve health care quality. Patient and family engagement is a critical strategy needed achieve these goals. The TCPI is recruiting 140,000 clinicians to participate in practice transformation, and is encouraging each and every one to involve patients and families in a meaningful way.

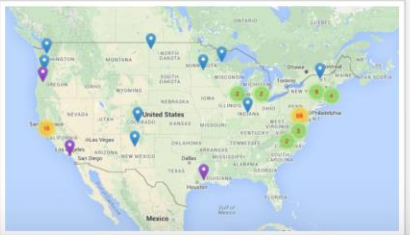
Transformation is possible!

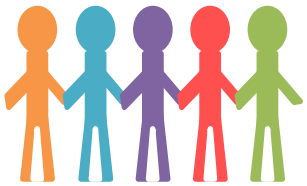
Patients may not know what to do to be involved in improving health care. Clinicians might not know what steps to take to get started or to improve even further. This website offers tools, training and information to support patients, families, and clinicians in making the transformation to person centered care. Use our resources to learn more about getting started, join our Patient-Family Advisory Council Network (the PFAC Network) to ask questions from your peers, or use our map to identify practices in your area.

Learn More

- About the PCPCC SAN
- For Patients And Families
- Clinicians and QI Staff
- Help With TCPI PFE Metrics
- Programs That Work!
- SAN Resource Library
- SAN Webinar Library
- Contact the PCPCC SAN

Involved In Patient-Family Engagement?
Join our PFAC Network to dialogue with peers





For Patients

Learn more about ways to be a partner in improving health care

PATIENTS ➡

For Clinicians and PTNs

Learn why patient and family engagement matters, and strategies to improve PFE measures

CLINICIANS ➡

SAN Resource Library

Practical information and tools to involve patients and families in improving health care quality

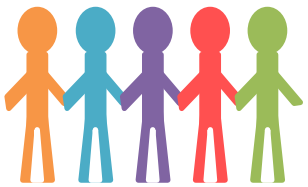
RESOURCES ➡

Questions?

Patient-Centered Primary Care COLLABORATIVE

Contact Us!

- Liza Greenberg, Program Director
  liza@pcpcc.net
- Jacinta Smith, Program Manager
  jacinta@pcpcc.net



https://www.pcpcc.org/tcpi