

The Medical Home Experience: Care Coordination and the Patient's Role in Shared Decision Making and Team Communication

Supported by the Center for PCMH Advancement

Welcome

Moderator:

Julie Schilz, BSN, MBA

PCPCC Co-Chair, Center for PCMH Advancement

Director, Patient Centered Care Transformation, WellPoint

The Medical Home Experience: Care Coordination and the Patient's Role in Shared Decision Making and Team Communication

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Date: Thursday, July 12, 2012

Time: 1 – 2:30pm ET

Speakers: Christine Bechtel

Vice President, National Partnership for Women & Families

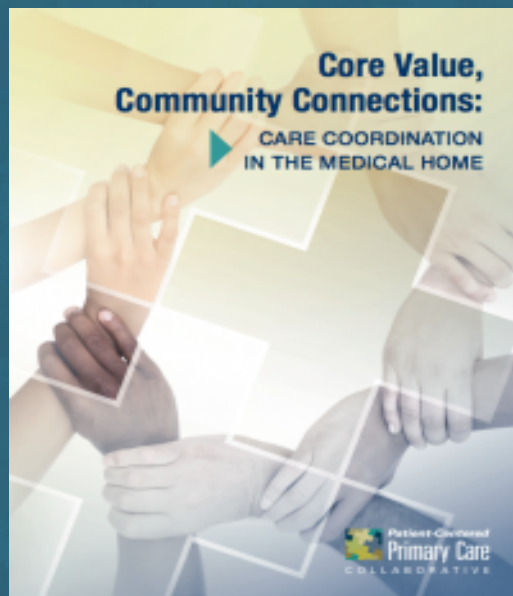
Melinda K. Abrams, M.S.

Vice President, Patient-Centered Coordinated Care Program

The Commonwealth Fund

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“I just want my doctors to talk to each other.”

- Quote from forward by Christine Bechtel, Vice President
National Partnership for Women & Families

This report features 3 core elements:

- 1) Expert-authored articles on the definition, role and function of care coordination, as well as tools for implementation, and measurement and monitoring of its effectiveness.
- 2) Case examples
- 3) Summary of survey responses from select practices

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Christine Bechtel

Vice President

National Partnership for Women & Families

Prior Appointments

- Vice President of eHealth Initiative (eHI)
- American Health Quality Association
- Senior Research Advisor, AARP

Community-based Quality Initiatives

- Director of Community Development, Louisiana's Medicare Quality Improvement Organization, Louisiana Health Care Review

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- Task Force on Academic Health Centers
- Commission on Women's Health
- Child Development and Preventive Care programs
- Grant awards program to state Medicaid agencies

Committees:

- Board of Managers for TransforMed
- Steering Committee for the Advanced Primary Care Demonstration at the Center for Medicare and Medicaid Innovation
- Medical Home panels for AHRQ

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Before we begin...

- All lines have been placed on mute
- Q&A session at end of event
- Polling questions throughout



The Medical Home Experience: Care Coordination

Christine Bechtel
Vice President

PCPCC Webinar
July 12, 2012


national partnership
for women & families

About us



▶ ***National Partnership for Women & Families***

- ▶ National, non-profit, consumer organization with 40 years' experience working on issues important to women and families

▶ ***Campaign for Better Care***

- ▶ Engage patients and consumers in re-design of our health care delivery and payment system
- ▶ Particular focus on meeting the needs of high need/high cost populations – older adults, complex chronic conditions
- ▶ More than 150 national, state, and local organizations



Agenda



- ▶ **Overview of Medical Home consumer messaging research**

- ▶ **Patient-Centered Care**
 - ▶ What does care coordination mean to patients?
 - ▶ Changing the paradigm; myth busting

- ▶ **How we know if we're getting care coordination right**
 - ▶ Collaborative consumer engagement

Our Research



- ▶ **Focus groups and national survey to develop ways to talk about delivery system reform in 2009 (*Health Affairs*, May 2010)**
 - ▶ Health IT
 - ▶ Medical Home
 - ▶ Payment Reform
 - ▶ Quality Measurement/Public Reporting
 - ▶ “Patient engagement” – shared decision making, patient experience
- ▶ **Medical Home (aka: Medical Home-base: A team approach to providing care)**
 - ▶ Favorable views because of emphasis on coordination and communication
 - ▶ Liked notion of a “point-person”
 - ▶ Resonated with treating the “whole person”
 - ▶ Concerns about how to pay for the model, gatekeeping, new fees
 - ▶ Liked “patient-centered” approach

Polling Question



- ▶ **How confident are you that you can define the term “patient-centered care”?**
 - ▶ Very confident
 - ▶ Somewhat confident
 - ▶ Not very confident
 - ▶ Not at all confident

Polling Question



- ▶ **How confident are you that your colleagues on this webinar would define it the same way?**
 - ▶ Very confident
 - ▶ Somewhat confident
 - ▶ Not very confident
 - ▶ Not at all confident

Patient-Centered Care **Definitions**



▶ **Institute of Medicine**

- ▶ Care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

▶ **Planetree**

- ▶ An approach to the planning, delivery and evaluation of care grounded in mutually beneficial partnerships among providers, patients and families. It redefines relationships in health care.

Consumer Definition



▶ Consumers & consumer orgs:

- ▶ **Whole person care:** clinicians understand the full range of factors affecting a patient's ability to get and stay well and treatment recommendations align with patients' values, life circumstances and preferences
- ▶ **Coordination and communication:** providers organized in teams and smooth transitions between settings
- ▶ **Patient support and empowerment:** expanding patients' and caregivers' capacity to get and stay well and support for self-management tools and services
- ▶ **Ready access:** getting appointments promptly and accommodating barriers such as language or physical or cognitive problems

Coordination and Communication



- ▶ “My doctors talk to each other – and to me”
- ▶ A “go-to” person available to answer questions, help **navigate** system, and help patients understand their condition and what they need to do
- ▶ Help **choosing** specialists or other services and **getting timely appointments**
- ▶ Having **complete information** at point of care; ensuring other providers have patient information in **advance**
 - ▶ Providing patient and caregiver **access to information**
- ▶ **Tracking** referrals and results; helping patients **understand** recommendations and follow up **actions**
- ▶ Providers **organized in teams** to address patient needs comprehensively
 - ▶ Patients and families know roles and responsibilities of team members

Coordination and Communication, ctd.



- ▶ Systems in place to **prevent errors and duplication** caused by multiple clinicians treating the same patient
 - ▶ Med reconciliation, electronic information exchange, shared medical records
- ▶ Helping patients with **insurance** eligibility, coverage and appeals (or referrals for assistance)
- ▶ Connecting patients to **community resources** (transportation, support groups, exercise programs, health literacy classes, etc.)
- ▶ Culture of **“taking responsibility”** for care coordination
 - ▶ Proactive, persistent, ongoing
 - ▶ Align actions of care team with patients’ health goals

These patients **want the moon!**



- ▶ **Getting to effective care coordination and patient-centeredness requires debunking myths:**
 - ▶ **Myth #1:** Patients always want everything.
 - ▶ **Myth #2:** What patients say they want is nice and important but we don't have time – what matters is clinical outcomes.
 - ▶ **Myth #3:** Doctors/clinicians know what patients want.
 - ▶ **Myth #4:** If we just build the system the right way, they will come.

Polling Question



- ▶ **How do/would you know if you’ re getting care coordination “right?”**
 - ▶ Because we implemented evidence-based practices
 - ▶ Because we got CMS/Other Payers to pay us for it
 - ▶ Because we asked patients and families and they said we were doing ok
 - ▶ Because we worked with patients and families to design and evaluate our processes

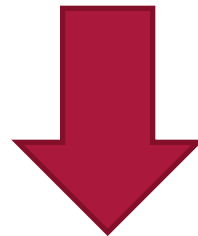
Getting Care Coordination **Right**



▶ Paradigm Shift:

What we need is “**Collaborative** Consumer Engagement”

Collaboration = Partnership



Patient-Centered Care

▶ How do we get patients to **tell us** what **they** need us to do?

....Right at Every Level



▶ Three Levels:

1. Engagement in **Care** – partnership to better manage care and improve health status based on patient’s own goals
 - ▶ shared decision making, joint goal setting, developing care plans
2. Engagement in **Practice Redesign** – working to redesign practices of care
 - ▶ care coordination, designing dx management programs, improving pt experience
3. Engagement in **Governance** – setting policy for initiatives or organizations
 - ▶ hiring staff, setting job descriptions, or setting qualification criteria or payment policies for medical home initiative

Examples of Partnership: **Redesign**



- ▶ **Jointly review, and develop solutions, in response to patient experience and other feedback data**
- ▶ **Engage patients/families in quality improvement and redesign efforts**
- ▶ **Engage patients/families in developing and vetting patient information, educational materials, websites/portals, care planning and support tools, including cultural/linguistic appropriateness**
- ▶ **Involve patients/families in staff orientation/training**
- ▶ **Involve patient/family advisors in “walk-throughs” to assess care delivery from patient perspectives**

Collaborative Consumer Engagement

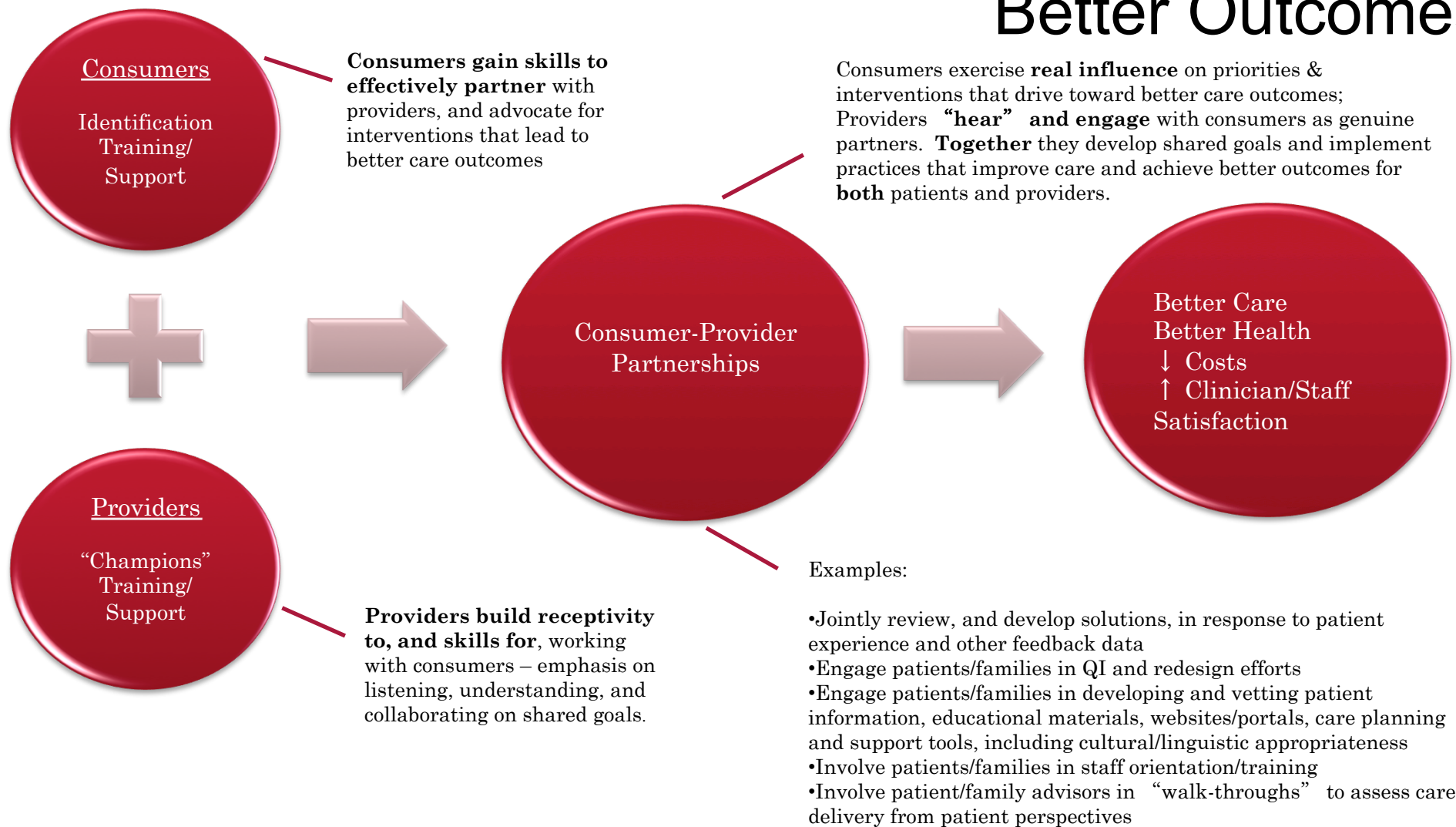


- ▶ Designing, implementing and evaluating care coordination processes and results **WITH** patients and families is key

IT IS NOT:

- ▶ Doing things *for* or *to* them, but not with them
- ▶ Getting consumers to do what we want them to do
 - ▶ Without them
- ▶ Consumer-Friendly/Patient-Focused Care
 - ▶ Providers still know best
 - ▶ Doing *for* patients

Collaborative Consumer Engagement Leads to Better Outcomes



Polling Question



- ▶ **How likely are you now to partner with patients and families to design/redesign your care coordination strategies?**
 - ▶ Very Likely
 - ▶ Somewhat Likely
 - ▶ I hope and pray we can
 - ▶ Not very likely (it's ok to be honest)
 - ▶ Not at all likely (feel free to call me and discuss)

For more information



Contact me:

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Follow us:



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www.NationalPartnership.org
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Care Coordination and Patient Engagement in The Medical Home

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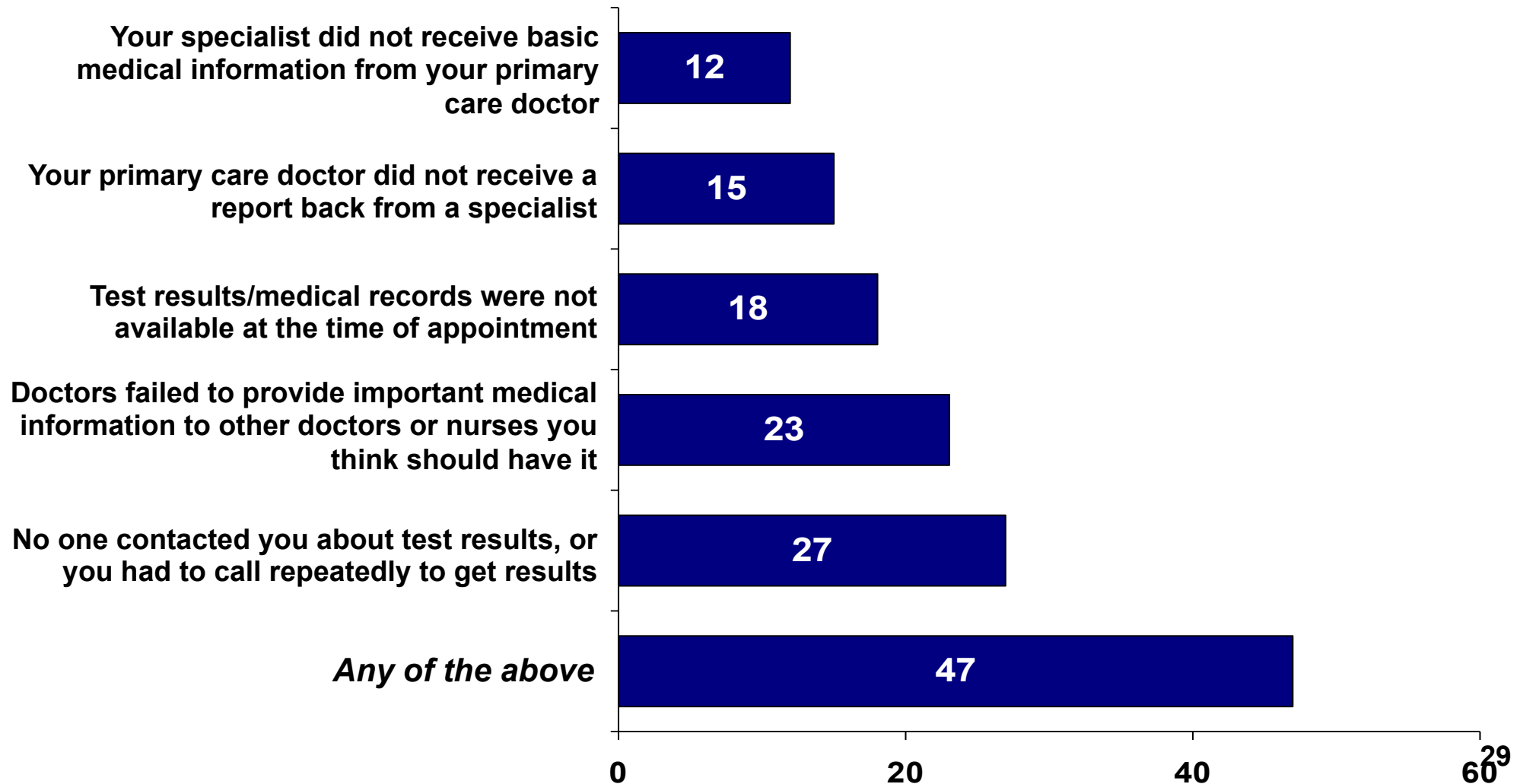
Polling Question

What percentage of U.S. adults have experienced a care coordination problem in the past two years?

- 10-15 percent
- 40-45 percent
- 70-75 percent
- 90-95 percent
- No idea

Poor Coordination: Nearly Half Report Failures to Coordinate Care

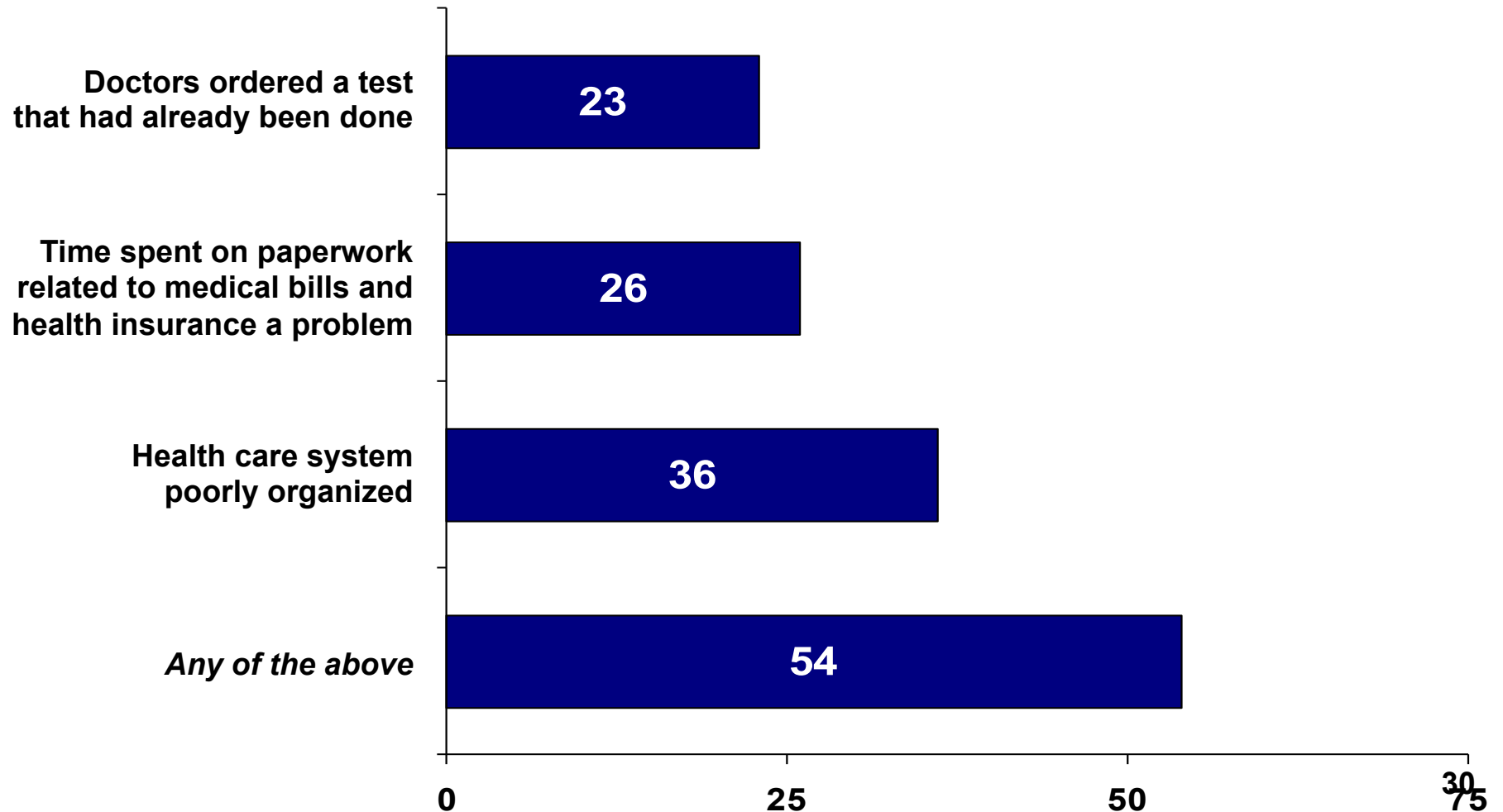
Percent U.S. adults reported in past two years:



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2011.

Inefficient System: More Than Half of U.S. Adults Experience Wasteful and Poorly Organized Care

Percent reporting in past two years:



Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2011.

Patient-Centered Care Associated with Better Processes of Care and Better Health Outcomes

Patients with positive patient experience are:

- More likely to follow physicians' advice and medication regimens
- More likely to stay with their primary care provider (improved loyalty and retention)
- Less likely to file malpractice complaints
- More likely to report better outcomes post hospital discharge, if their ambulatory care experience was positive
- Often more likely to receive better process of care (e.g., preventive care screening, chronic disease management)

Patient Activation* Level is Predictive of Behaviors

Research consistently finds that those who are more activated are:

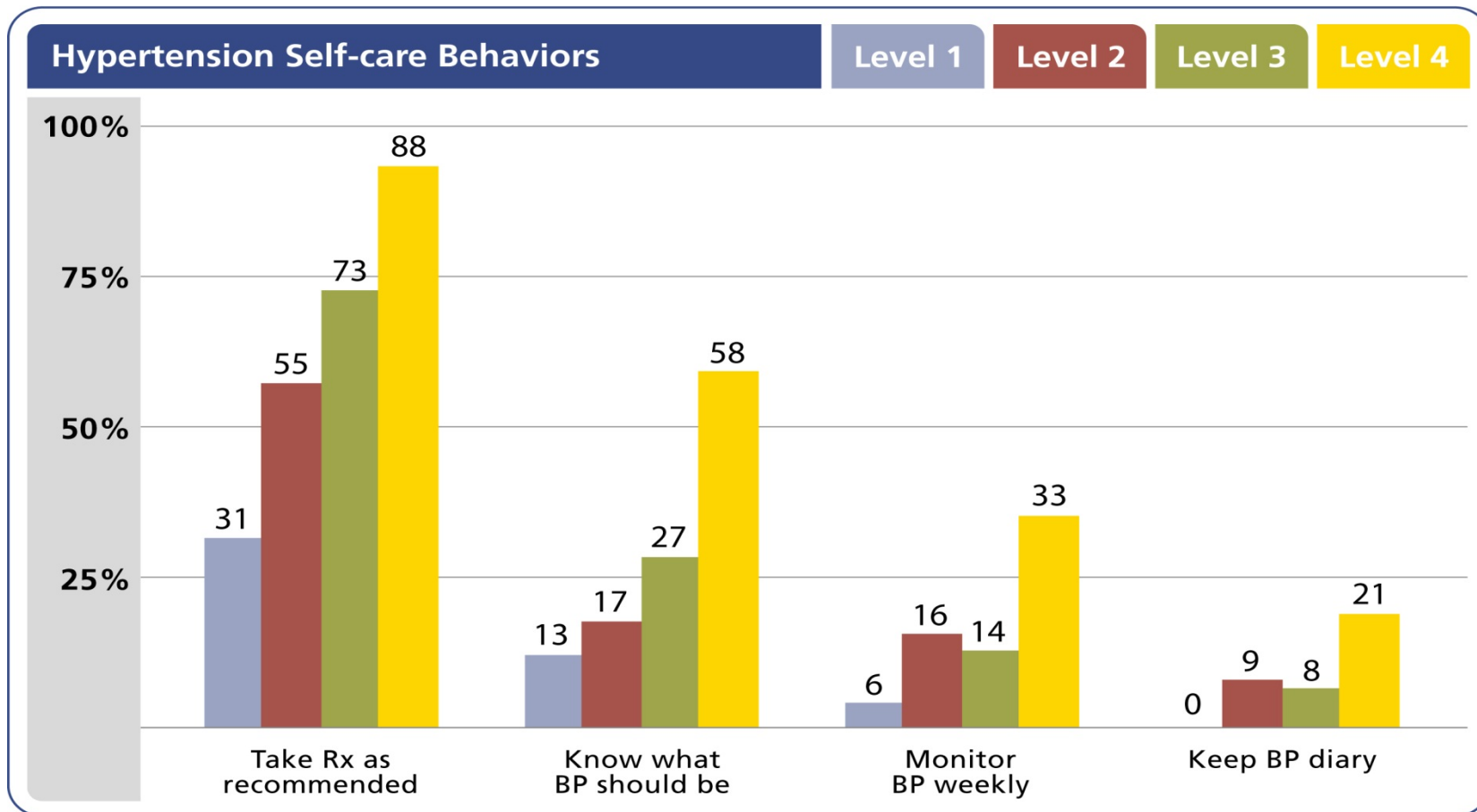
- Engaged in more preventive behaviors
- Engaged in more healthy behaviors
- Engaged in more disease specific self-management behaviors
- Engaged in more health information seeking behaviors

*Activated patients are patients who have the motivation, knowledge, skills, and confidence to make effective decisions to manage their health.

Source: J. Hibbard, “Patient Activation and Engagement for ACOs,” The Centers for Medicare and Medicaid Innovation Webinar, January 24, 2012. https://acoregister.rti.org/index.cfm?fuseaction=dsp_web

J. Greene and J. Hibbard, “Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes.” Journal of General Internal Medicine, May 2012.

Level of Patient Activation is Linked with Hypertension Self Care Behaviors



Source: US National sample 2004

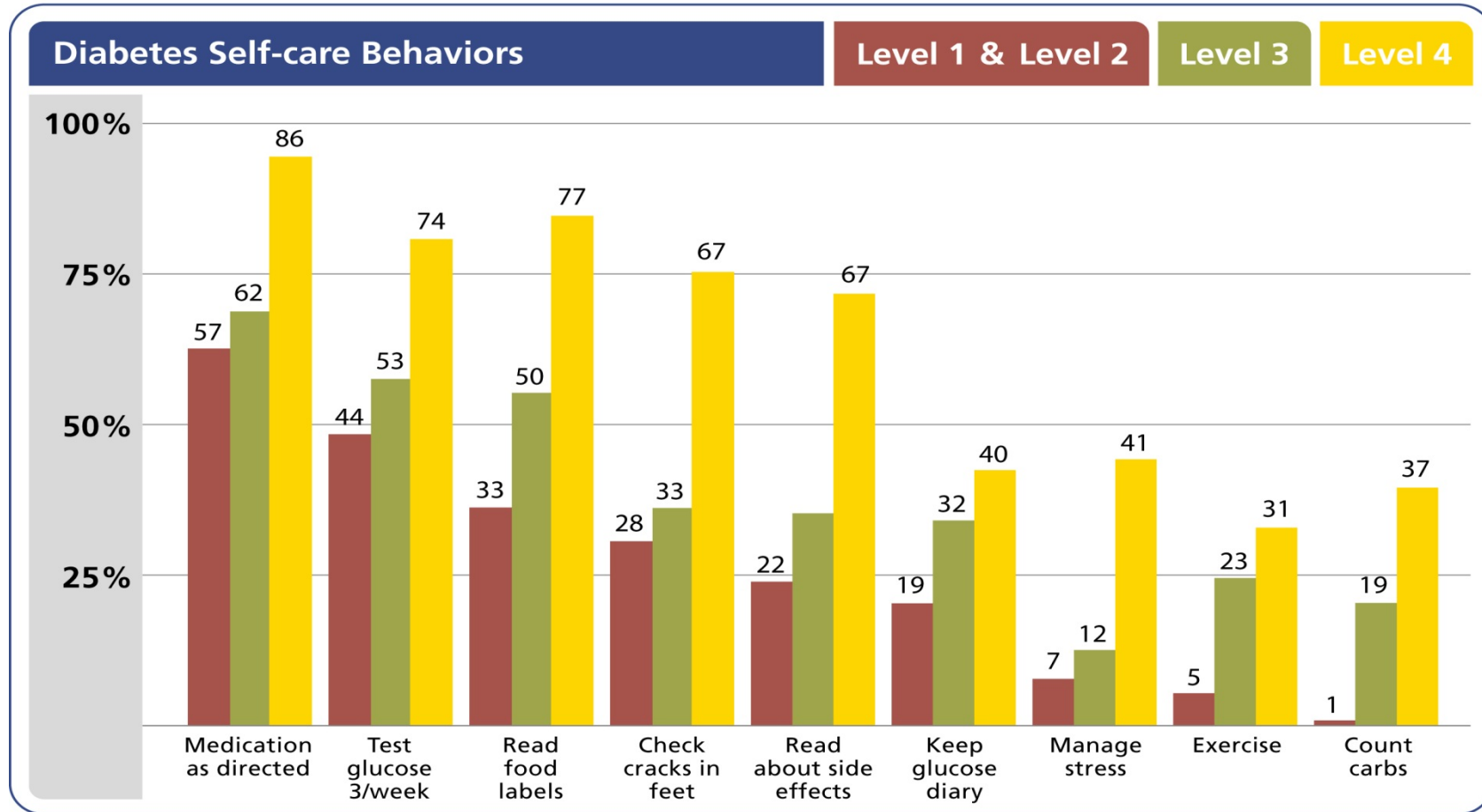
Source: J. Hibbard, "Patient Activation and Engagement for ACOs," The Centers for Medicare and Medicaid Innovation Webinar, January 24, 2012.

https://acoregister.rti.org/index.cfm?fuseaction=dsp_web

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J. Greene and J. Hibbard, "Why does patient activation matter? An examination of the relationships between patient activation and health-related outcomes." Journal of General Internal Medicine, May 2012.

Level of Patient Activation is Linked with Diabetes Self-Care Measures

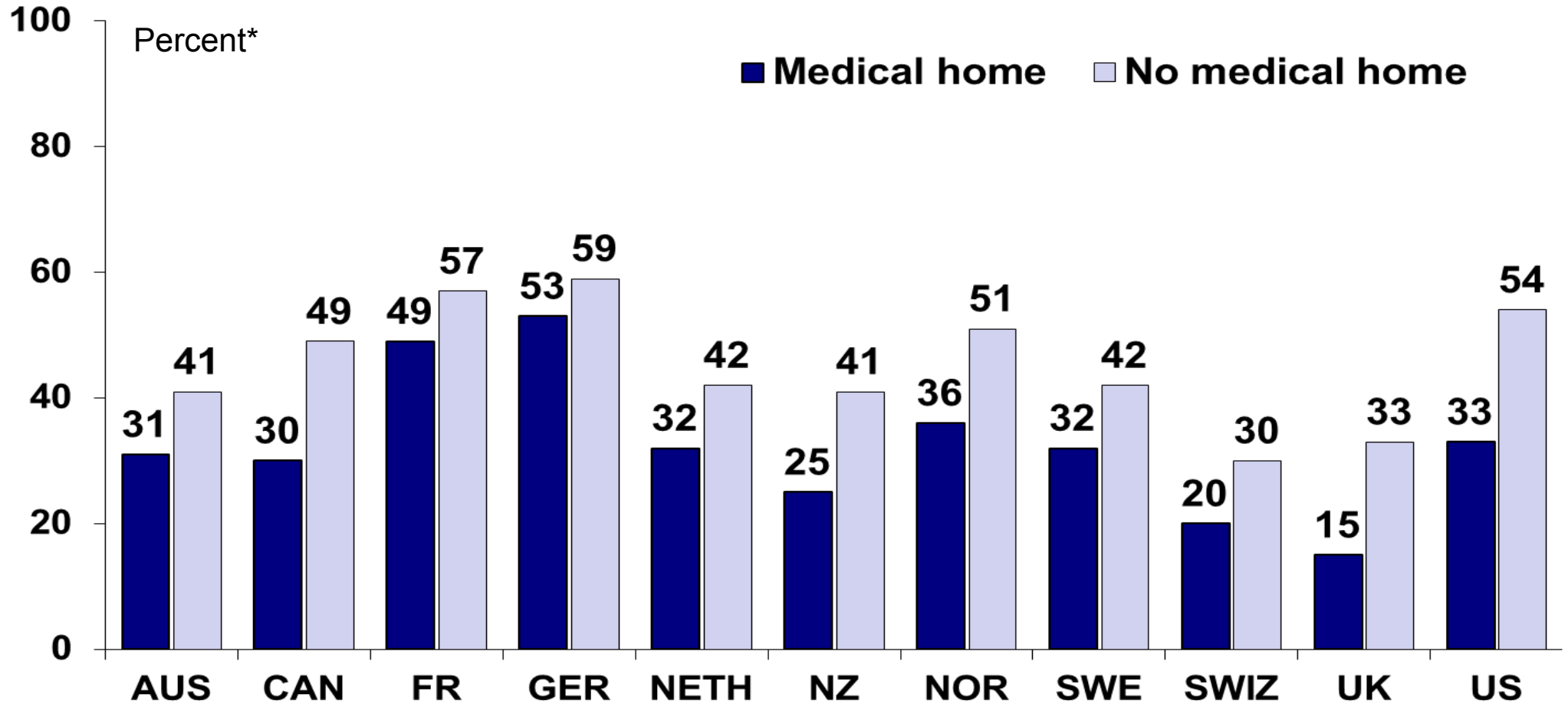


RWJ PeaceHealth Study 2006

Source: J. Hibbard, "Patient Activation and Engagement for ACOs," The Centers for Medicare and Medicaid Innovation Webinar, January 24, 2012. https://acoregister.rti.org/index.cfm?fuseaction=dsp_web

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Patients with Medical Homes Less Likely to Report Coordination Gaps in the Past Two Years

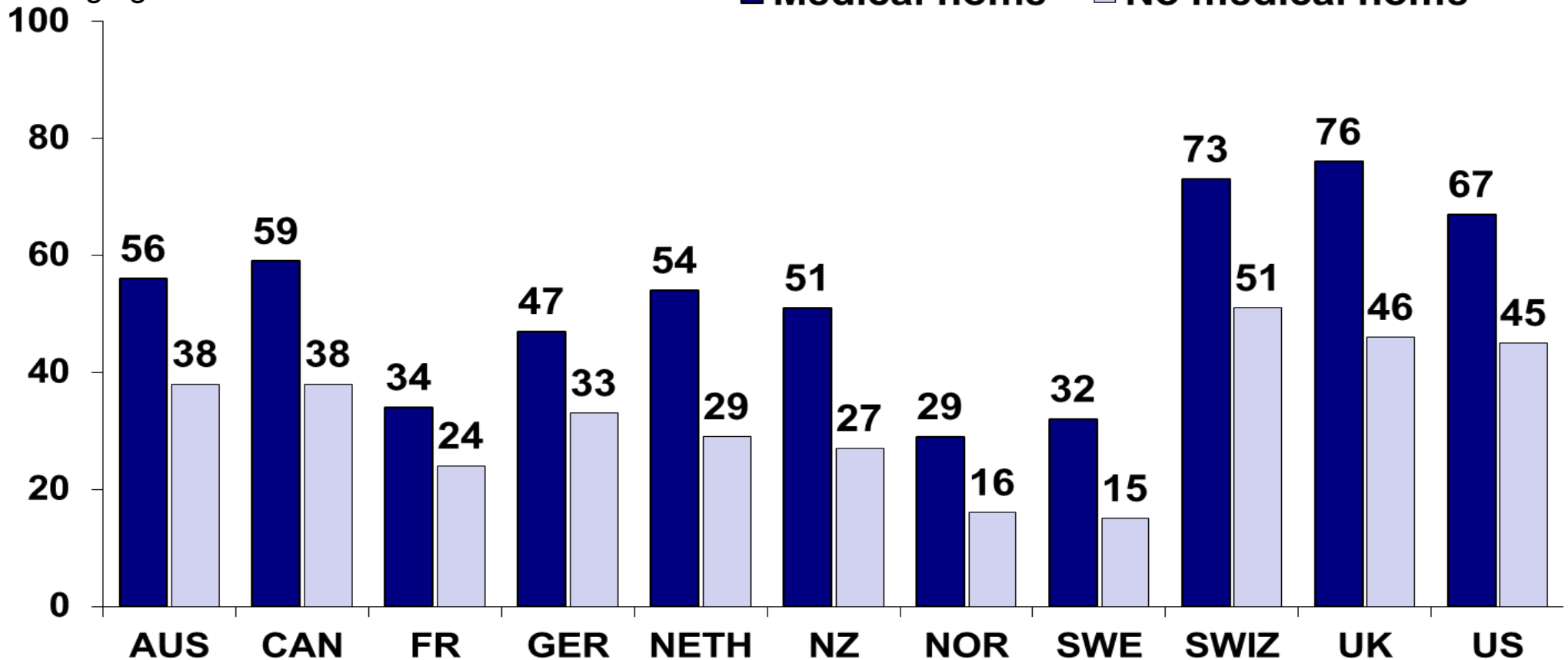


* Test results/records not available at time of appointment, doctors ordered test that had already been done, providers failed to share important information with each other, specialist did not have information about medical history, and/or regular doctor not informed about specialist care.

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.

Patients with Medical Homes Report Higher Levels of Patient Engagement

Percent reporting positive patient engagement in managing chronic condition*



* Health care professional in past year has: 1) discussed your main goals/priorities in care for condition; 2) helped make treatment plan you could carry out in daily life; and 3) given clear instructions on symptoms and when to seek care.

Base: Has chronic condition.

What is Care Coordination?

“Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.”

Setting Up Systems to Monitor Performance of Care Coordination in Medical Homes

**Critical to Understand if Patients'
Needs Are Being Met**

Polling Question

How often do you collect and discuss performance data about how well you coordinate your patients' care?

- We don't. Hence, the webinar
- We collect lots of data, but never have time to discuss it
- Annually
- Monthly to quarterly
- Everyday

Seven Key Changes to Set up Performance Monitoring System

1. Work with a broad stakeholder group
2. Clarify purpose of measurement
3. Use standardized measures
4. Incorporate patients and families feedback
5. Develop a tracking system
6. Build and nurture relationships
7. Use the data

1. **Work with a Broad Group of Stakeholders to Reach Consensus on Measures**

- Involve executive leadership, clinical teams, front-desk staff
- Involve patients and families!
 - Ensures buy-in and increases follow-up action

2. Articulate Clarity of Purpose

Recognize the implications of your choice

- **Quality Improvement?**
 - To modify intervention
- **Accountability or benchmarking?**
 - To attain incentive, recognition or bonus
- **Evaluation?**
 - To assess if the model should be sustained or spread

3. Use Standardized, Nationally Endorsed Measures

- Enables fair comparisons about quality of care coordination (referrals, follow-up, transitions, etc.)
- Enables comparison to national benchmarks
- Saves time
- No shortage of measures, but little consistency in use
- Select measures that matter

Polling Question

How do you know if your patients think you're doing a good job coordinating their care?

- We survey our patients
- We hold focus groups or ask our advisory council
- We ask them to use our 'suggestion box'
- We just know – they complain
- We don't know

4. Incorporate Patient and Family Feedback to Assess Quality of Coordination

- Patient surveys about their experience
- Focus groups
- Patient and family advisory councils
- Comment cards

5. Develop a Tracking System that Monitors Performance

- Incorporate into workflow
 - Need written procedures, protocols for how to share information between providers and between providers and patients
- Use Information technology
- Care Coordination Agreements (CCAs) can specify responsibilities of different providers

6. Build Relationships with Providers in Your Medical Neighborhood

- The success of technical system depends on strength of the interpersonal relationships
- Continue to convene your broad stakeholder group to obtain feedback on process as well as to review performance data

7. Share Results at Practice and Care-Team Levels to Improve Care Coordination

Measurement Wall at Community Health Partners in Montana:



Tips for Data Reporting to Drive Quality Improvement

- Ensure all staff members understand the metrics for success
 - Collect stories from patients
 - Review aim of PCMH with patients
 - Review progress at team meetings, with patient advisory council, with leadership
- Select a visible or easily accessible location for data reports, update often

Polling Question

Which key change discussed today can you implement (or improve) in the next 3 months?

- Convene stakeholder group to devise a measurement strategy
- Clarify the purpose of our measurement activities
- Incorporate patient/family feedback
- Develop a system to make data collection routine
- Improve how we display, share and act on the results

Thank You!



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**For more information, please visit:
www.commonwealthfund.org**

Appendix:

Resources to Help Select Care Coordination Measures

- **AHRQ Care Coordination Measurement Atlas** (<http://www.ahrq.gov/qual/careatlas/>)
- **MacColl/Qualis comparison of care coordination questions from patient experience surveys** (<http://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Patient-Centered-Interactions-1.pdf>)
- **National Quality Forum's National Priorities Partnership** (http://www.qualityforum.org/Setting_Priorities/NPP/National_Priorities_Partnership.aspx)
- **For evaluation, the Patient Centered Medical Home Evaluators' Collaborative core, recommended measures (limited)** (<http://www.commonwealthfund.org/Publications/Data-Briefs/2012/May/Measures-Medical-Home.aspx>)
- **NCQA PCMH Standards: care coordination measures** (<http://www.ncqa.org/tabid/631/Default.aspx>)

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Questions

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Thank You