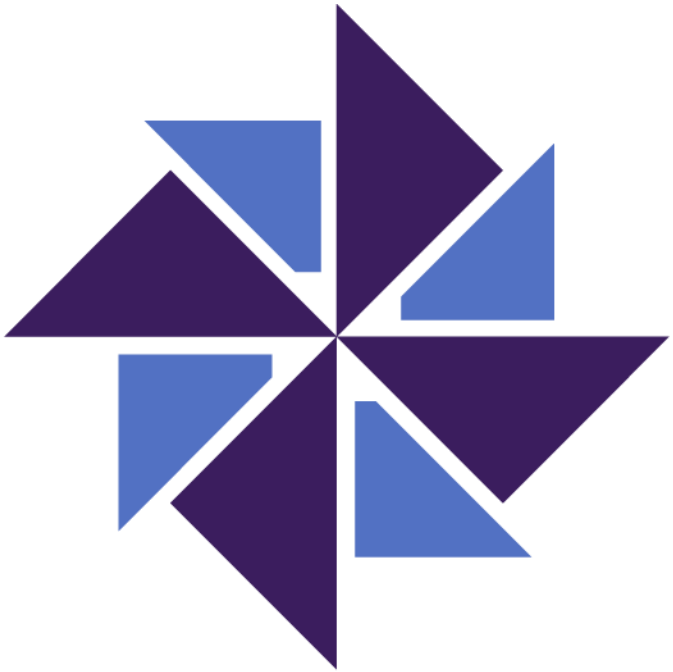


INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

www.ipfcc.org

The BIG Picture:

The Quadruple Aim of Healthcare Reform, Transforming Clinical Practice Initiative, and Why We Need Patient, Family, and Community Partners

Beverley H. Johnson
IPFCC President and CEO

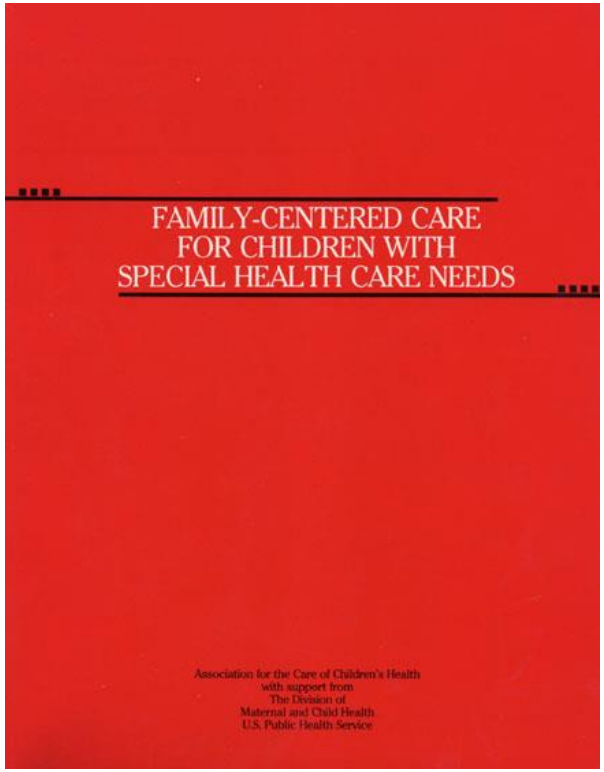
PCPCC Annual Conference
Washington, DC
November 11, 2016

In our time together . . .

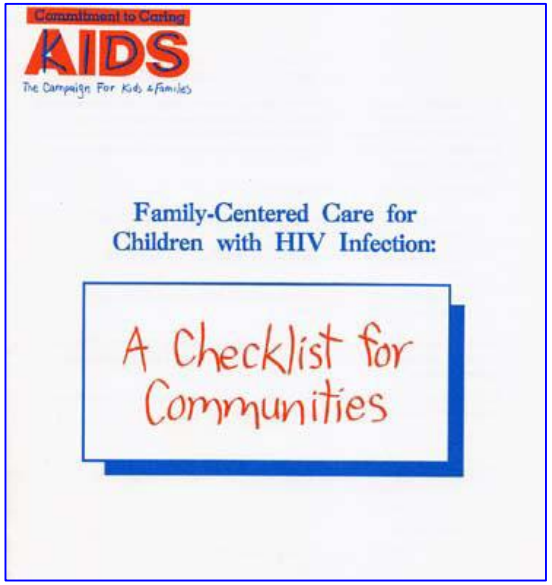
- Develop a shared understanding of the historical evolution of patient- and family-centered care and how it relates to transforming clinical practices in ambulatory settings with patients, families, and communities.
- Describe the Triple Aim and Qradruple Aim and the roles of patient, family, and community partnerships.
- Discuss how partnerships with patients, families, and communities are a consistent theme in the change and improvement of the health care system over the last 35 years.

1980s

1983



1985

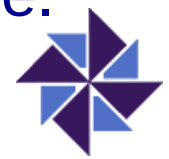


1988

1990s

Patient- and Family-Centered Core Concepts

- People are treated with **respect and dignity**.
- Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.
- Patients and families are encouraged and supported in **participating in care and decision-making** at the level they choose.
- **Collaboration** among patients, families, and providers occurs in policy and program development and professional education, as well as in the delivery of care.



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




W. Carl Cooley, MD, Pioneer for the Medical Home

- The beginning . . .early 1990's
  - Office-Based Improvement…physician, office manager, and a family advisor.
  - Family-centered, coordinated, community-based care.
  - Medical Homes in New Hampshire with families involved from the beginning.

Office-Based Quality Improvement Center for Medical Home Improvement

Pediatricians, family medicine physicians, and families working together to assure that all children have access to family-centered, culturally competent, coordinated, comprehensive primary care (*Pediatrics*, 2002).

Quality improvement methodology

- Core team: MD, Nurse or Case Manager, and a parent.
- Rapid cycle improvement.
- Developing a system of care, tracking, and monitoring children with special needs.

www.medicalhomeinfo.org/about/ www.medicalhomeimprovement.org

Cooley, W. C., McAllister, J. W., Sherrieb, K., & Khulthau, K. (2009). Improved outcomes associated with medical home implementation in pediatric primary care. *Pediatrics, 124, 358-364.*

1999-2003

CHILD HEALTH TOPICS

Asthma

Asthma is a disease that affects the lungs and can cause breathlessness, chest tightness, coughing and wheezing. Asthma is one of the most common, chronic, long-term diseases of children, with a diagnosis prevalence of 1 in every 11 children. Asthma is the third leading cause of hospitalization among children under the age of 15. Control of asthma requires appropriate diagnosis, effective use of medications, knowledge and understanding of the causes and consequences of the disease.

How We're Helping

Through multiple projects, we have worked to develop, implement and evaluate sustainable approaches to improving care and outcomes for patients with childhood asthma.

The exact cause of asthma is unknown, and asthma cannot be cured. However, asthma can be controlled. Triggers for asthma can include mold, tobacco smoke, outdoor air pollution, and infections linked to influenza, colds, and other viruses. Avoiding these triggers, along with using inhaled corticosteroids and other medicines, are the keys to preventing an asthma attack.

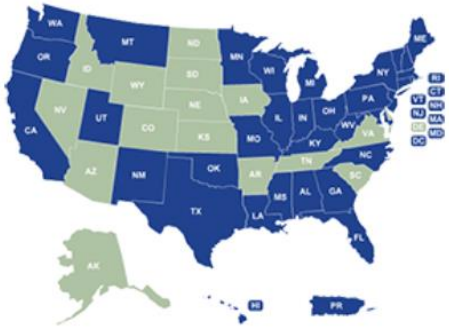
Florida Learning and Action Network and Asthma Care Team Programs

Asthma Jump Start

California Plan Practice Improvement Project (PPIP)

What Causes Asthma?

The exact cause of asthma is unknown, and asthma cannot be cured. However, asthma can be controlled. Triggers for asthma can include mold, tobacco smoke, outdoor air pollution, and infections linked to influenza, colds, and other viruses. Avoiding these triggers, along with using inhaled corticosteroids and other medicines, are the keys to preventing an asthma attack. *Source: CDC*



Asthma State Profiles

The CDC's National Center for Environmental Health (NCEH) publishes Asthma State Profiles to provide information about the number of people who are affected by asthma in the states that are part of the CDC National Asthma Control Program.

2000

Study of Communication in Outpatient Visits

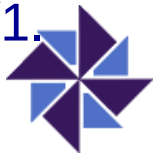
When patients achieved common ground with physicians, health status improved, emotional health improved, fewer referrals and diagnostic tests needed two months after the visit.

Stewart, M., et al. The Impact of Patient-Centered Care on Outcomes, *Journal of Family Medicine*, 2000.

2003

High Plains Research Network (HPRN) Community Advisory Council, Colorado

- Since 2003, the Community Advisory Council has participated in all aspects of the HPRN research.
- An all day “boot camp” is held prior to working on a project. Projects have included:
  - Testing to Prevent Colon Cancer in Rural Colorado
  - Asthma Toolkits and Community Asthma Integration and Resources (AIR) (Asthma awareness and management)
  - Under-insurance
  - Patient-centered medical home
  - Patient harm/medical mistakes
- For further information: Westfall, J. M., VanVorst, R. F., Main, D. S., & Herbert, C. (2006). Supplemental case report: Community involvement in a practice-based research network. *Annals of Family Medicine, 4*(1), 8-14. Retrieved from http://www.annfammed.org/cgi/data/4/1/8/DC1/1.



High Plains Research Network (HPRN) Community Advisory Council, Colorado (cont'd)

Connecting with the Gun Club . . .

High Plains Research Network (HPRN) Community Advisory Council, Colorado (cont'd)

"The Community Advisory Council has made our research ten times better, much more relevant to the communities we serve. In addition, it's a lot of fun to work with the Community Advisory Council."

Jack Westfall, MD, MPH

2005-2013

and continuing

Results in Marion County

WVP HEALTH AUTHORITY

Impact of a Peer-led Substance Abuse Program for Pregnant Moms.

The number of babies taken at birth for a positive drug screen in Marion county has dropped from:

- 114 in 2005;
- 12 in 2010;
- 9 in 2011;
- 11 in 2012; and
- 10 in 2013

99.4% of babies of <u>enrolled</u> MOMS participants tested negative for illegal drugs at birth. The moms of the two babies who tested positive, had only been enrolled for less than a month

2006

Patient-Centered Primary Care COLLABORATIVE

Founded in 2006, the Patient-Centered Primary Collaborative (PCPCC) is a not-for-profit membership organization dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home.

2007

The Joint Principles for the Patient-Centered Medical Home . . . An Opportunity

- “. . . A care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. . .
- Patients actively participate in decision-making. . .
- Care is coordinated. . .in a culturally and linguistically appropriate way.
- Information technology is utilized appropriately to support . . . enhanced communication.
- Patients and families participate in quality improvement at the practice level.”

2010

Health Care Reform in the United States

- A Consistent Theme of Patient and Family Engagement at all Levels
- The Affordable Care Act of 2010
  - Primary care redesign, increased access, and further integration with mental health.
  - Partnerships for Patients: Better Care and Lower costs — Reduction in preventable hospital acquired conditions and readmissions

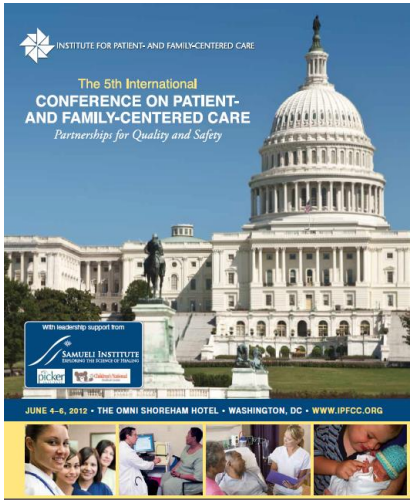
Affordable Care Act 2010

- "The law includes provisions to communicate health and health care information clearly; promote prevention; be patient-centered and create medical or health homes; assure equity and cultural competence; and deliver high-quality care."

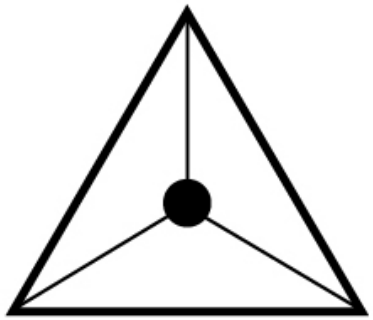
Source: Somers, S. A., & Mahadevan, R. (2010). *Health Literacy Implications of the Affordable Care Act. Available at* http://iom.nationalacademies.org/

2012

Triple Aim — Patient- and Family-Centered Care



Health of Populations



Patient Experience

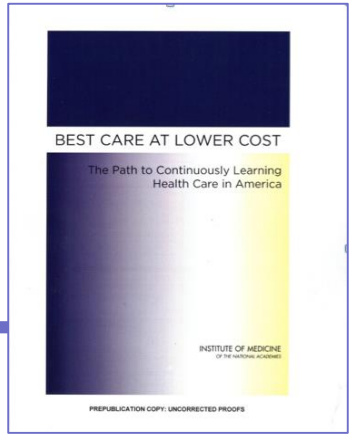
Reducing Costs

"The most direct route to the **Triple Aim** is via patient- and family-centered care in its fullest form."

Don Berwick

June 5, 2012

Best Care at Lower Cost: The Path to Continuously Learning Health Care in America

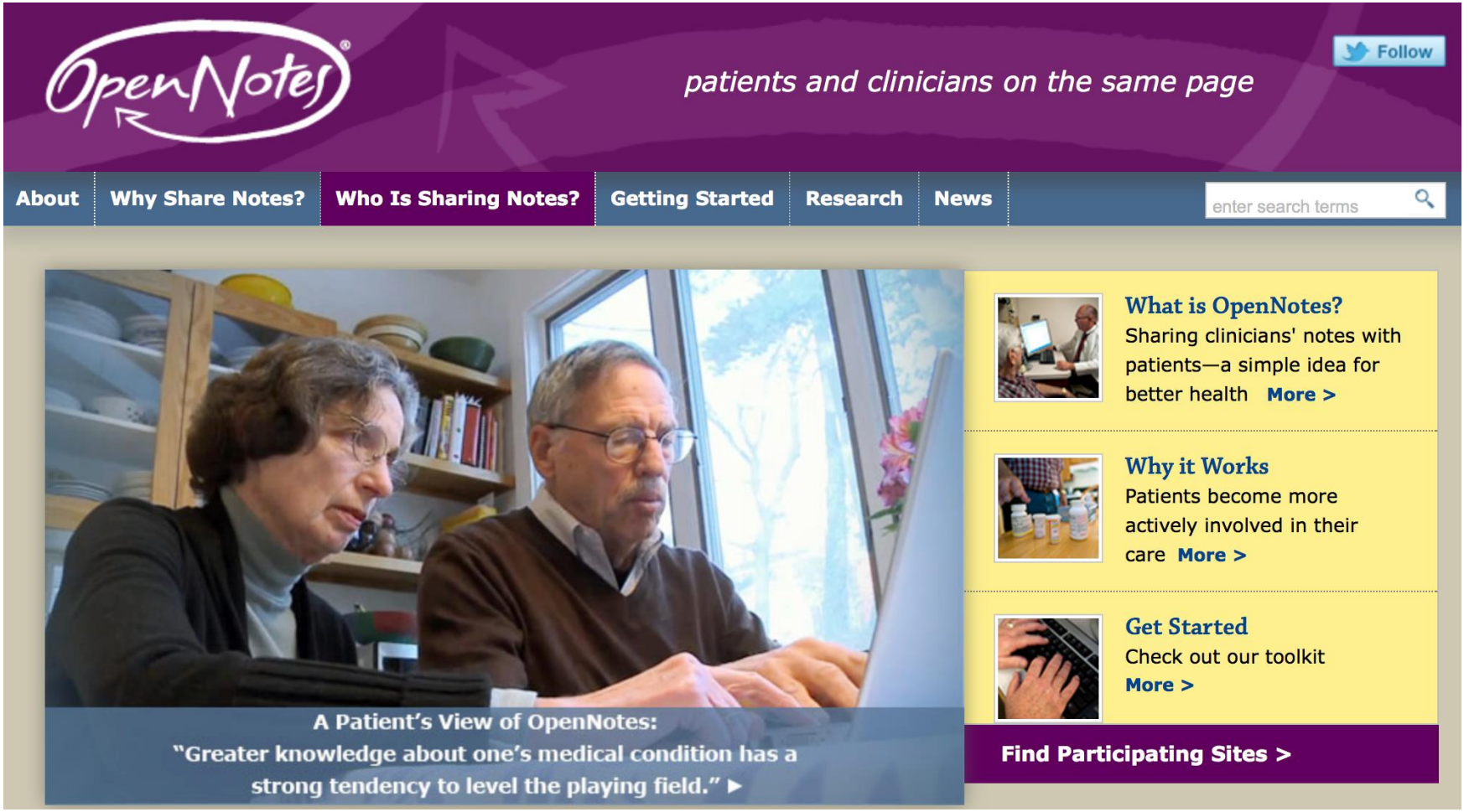


The IOM report has 10 key recommendations; the 4th recommendation states:

"Patients and families should be given the opportunity to be fully engaged participants at all levels, including **individual care decisions**, **health system learning and improvement** activities, and **community-based interventions to promote health**." S-23

"In a learning health care system, patient needs and perspectives are factored into the **design of health care processes**, the **creation and use of technologies**, and the **training of clinicians**." 5-5.

http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx



http://www.myopennotes.org

2013

Fort Collins Family Medicine Group Pain Clinic

A strengths-based, empowering, patient- and family-centered approach to chronic pain management.

Integration of physical health, behavioral health, and community partnerships.

Partnered with community resources for volunteer opportunities and for learning experiences for massage students.

2013

American College of Physicians
Leading Internal Medicine, Improving Lives

American College of Physicians creates Center for Patient Partnership in Healthcare to advance collaboration between physicians and patients

Goal is to help patients become informed advocates and active partners in their care

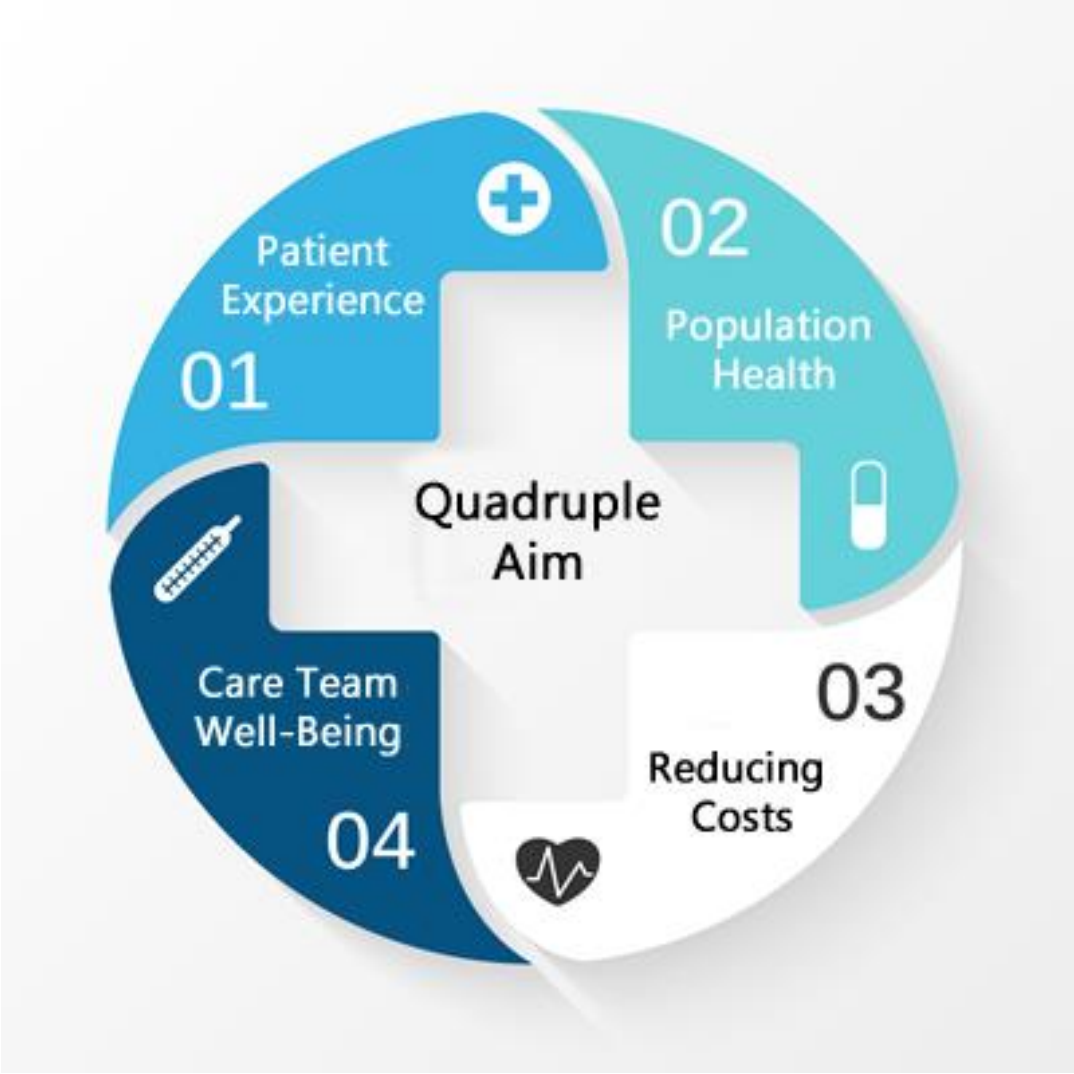
2014

Robert Wood Johnson Foundation

In it Together— Building a Culture of Health

2015 President's Message

Risa Lavizzo-Mourey, MD, MBA
President and Chief Executive Officer



Source of Graphic: HITEQ Center. Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine*, *12*(6), 573-576.

VIEWPOINT

Challenges at the Intersection of Team-Based and Patient-Centered Health Care

Insights From an IOM Working Group

Matthew K. Wynia, MD, MPH
Isabelle Von Kohorn, MD, PhD
Pamela H. Mitchell, PhD, RN

are used to describe team-based care, th
ful. Is the patient the quarterback? Th
has a different quarterback or coach e
would this vary according to the team's p
for example, teams for patients receiv

"In high-functioning health care teams, patients are members of the team; not simply objects of the team's attention…"


JOY

Bruner Family Medicine Center
Denver, CO

"*Even when I have been up all night, I find attending the Patient and Family Advisory Board energizing.*”

Aaron Gale, Medical Director, Bruner Family Medicine Center, Denver, CO

Patient and family advisors at Ocean Park Health Center, San Francisco, CA

Patient and family advisors planned the “walk and talk series.”

Ocean Park Health Center
San Francisco, CA

The Patient Advisory Council members have been enthusiastic, and interested in improving care of patients and outreaching to the community.

Each time I attend their meetings, their energy and passion revitalizes me and helps me to remember the reasons for which we are all here: to serve our patients.

Lisa Golden, MD, Medical Director
Ocean Park Health Center,
San Francisco, CA

2015

TCPi Transforming Clinical Practices Initiative

- A four-year CMS initiative for the U.S., designed to help clinicians achieve large-scale health transformation (2015 – 2019).
- Support more than 140,000 clinician practices in sharing, adapting, and further developing comprehensive quality improvement strategies.
- One of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation.

https://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/

TCPi | Transforming Clinical Practice Initiative

TCPI Change Package: Transforming Clinical Practice

Driver Diagram

The TCPI Change Package, which is built on the driver diagram model below, describes the changes needed to transform clinical practice and meet TCPI goals. The driver diagram shows the relationships among goals, the primary drivers that contribute to achieving those goals, and the subsequent factors that are necessary to achieve the primary drivers. The change package is a compilation of the interventions developed and tested by others.

TCPI AIMs/Goals

(1) Support more than 140,000 clinicians in their practice transformation work.

(2) Build the evidence based on practice transformation so that effective solutions can be scaled.

(3) Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients.

(4) Reduce unnecessary hospitalizations for 5 million patients.

(5) Sustain efficient care delivery by reducing unnecessary testing and procedures.

(6) Generate $1 to $4 billion in savings to the federal government and commercial payers.

(7) Transition 75% of practices completing the program to participate in Alternative Payment Models

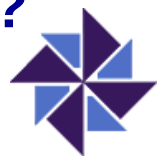
Primary Drivers	Secondary Drivers
Patient and Family-Centered Care Design	1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence based care 1.7 Enhanced Access
Continuous, Data-Driven Quality Improvement	2.1 Engaged and committed leadership 2.2 Quality improvement strategy supporting a culture of quality and safety 2.3 Transparent measurement and monitoring 2.4 Optimal use of HIT
Sustainable Business Operations	3.1 Strategic use of practice revenue 3.2 Staff vitality and joy in work 3.3 Capability to analyze and document value 3.4 Efficiency of operation

www.nrhi.org/uploads/tcpi-change-package_color_march-16_v20.pdf

TCPi Transforming Clinical Practices Initiative PFE Metrics (draft)

Does the practice . . .

1. Use an e-tool accessible to share information such as test results, medication management list, vitals, and other data?
2. Support shared decision-making by training and ensuring clinicians integrate patient goals and preferences into care plan?
3. Use a tool to assess and measure patient activation?
4. Use the CAHPS Health Literacy Item Set?
5. Promote patient-centric medication management practices (self management of medication, etc.)?
6. **Have policies, procedures and actions taken to support patient and family participants in governance or operational decision-making committees of the practice (Person and Family Advisory Councils, Board Representatives, etc.)?**



Primary Care Corner . . .

- IPFCC is partnering with the Patient-Centered Primary Care Collaborative (PCPCC) as part of its Transforming Clinical Practice Initiative (TCPI) Support and Alignment Network (SAN).
- The Primary Care Corner column provides monthly stories and highlights from the field.
- To receive this free e-newsletter: www.ipfcc.org/join.html

Building Peer Support In TCPI Practices

http://www.ipfcc.org/advance/topics/peer-mentor-programs.html

New York Academy for Medicine

PLANETREE

the YMCA

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Planetree will provide expertise in educational development and coaching; creating patient/family-centered tools and trainings, peer-to-peer sharing, and engaging community stakeholders in transforming health care from the patients' perspective.

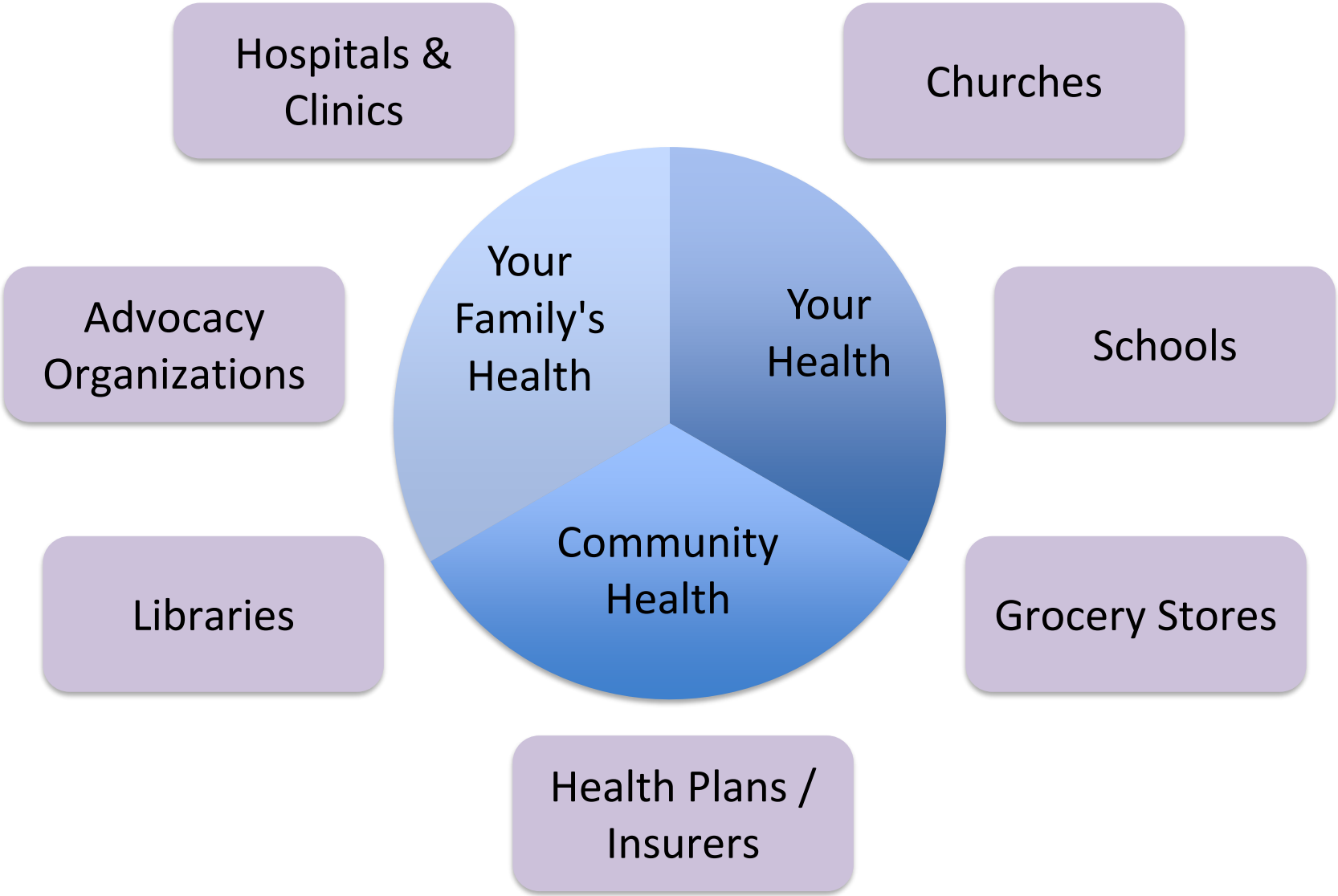
YMCA will advance a model of community-integrated health in which the YMCA will promote clinic-to-community linkages to help patients improve self-management of chronic conditions. New models of collaboration between clinicians and community-based organizations will be tested.

In Conclusion . . .

"Our patients and their families are an abundant source of wisdom as we navigate the stormy seas of healthcare delivery.

To go it alone without their partnership is foolish and unwise. With patients as equal partners in this journey, our work together is more fulfilling, more meaningful, and more likely to help them reach their health goals."

Joseph Bianco, MD, FAAFP, Director of Primary Care for Essentia, Ely, MN


Hospitals & Clinics
Churches
Advocacy Organizations
Schools
Your Family's Health
Your Health
Community Health
Libraries
Grocery Stores
Health Plans / Insurers

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