Transforming Clinical Practices Initiative
Patient, Caregiver & Community Engagement
Support & Alignment Network (PaCCE SAN)

PCPCC National Briefing
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Welcome & Acknowledgments

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PCPCC: What We Do

Our Mission
• Dedicated to advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH).

Activities
• Educate stakeholders and strengthen public policy that advances and builds support for primary care and the medical home
• Disseminate results and outcomes from advanced primary care and PCMH initiatives and clearly communicate their impact on patient experience, quality of care, population health and health care costs
• Convene health care experts and patients to promote learning, awareness, and innovation of primary care and the medical home
Overall Goal: Health system transformation

- Delivery Reform
- Payment Reform & Benefit Redesign
- Trained Health Work Force
- Public Engagement
Outcomes of Advanced Primary Care

- Cost Savings
- Fewer ED/Hospital Visits
- Improved Access
- Increased Preventive Services
- Improved Health
- Improved Patient & Clinician Satisfaction

Mapping Primary Care Innovations

Map of PCMH initiatives with reported outcomes

What are the critical pieces to practice transformation?
PCPCC Recipient of TCPI Funding!

• 1 of 39 selected in 2015 for Transforming Clinical Practice Initiative (TCPI).
• 1 of 10 Support & Alignment Networks (SAN)
• **PCPCC SAN:** Patient, Caregiver & Community Engagement Support & Alignment Network (PaCCE SAN)
  – The PaCCE SAN will provide technical assistance to participating practices and networks across the US in order to promote deeper patient relationships and community engagement among care teams.
TCPI Goals

- Support >140,000 clinicians in their practice transformation work
- Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients
- Reduce unnecessary hospitalizations for 5 million patients
- Generate $1 to $4 billion in savings to the federal government and commercial payers
- Sustain efficient care delivery by reducing unnecessary testing & procedures
- Build the evidence base on practice transformation so that effective solutions can be scaled
Overall Aims of the TCPI Model

1. Transform Practice.
   Support more than 140,000 clinicians in work to achieve practice transformation

2. High Performance.
   Improve health outcomes for 5M Medicare, Medicaid & CHIP beneficiaries.

3. Reduce Utilization.
   Reduce unnecessary hospitalizations & over utilization of other services for 5M Medicare, Medicaid & CHIP beneficiaries

4. Scale.
   Build the evidence base on practice transformation so that effective solutions can be scaled, if successful

5. Savings.
   $1B–$4B in savings to federal government over... 4 years through reduced Medicare, Medicaid & CHIP expenditures

6. Value Based.
   Move clinicians through the TCPI phases to participate in incentive programs & practice models that reward value

Logic Flow
Transforming Clinical Practice would employ a **three-prong approach** to national technical assistance.

**Aligned federal and state programs with support contractor resources**

**Practice Transformation Networks to provide on the ground support to practices**

**Support and Alignment Networks to achieve alignment with medical education, maintenance of certification, more**

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This technical assistance would enable large-scale transformation of more than **140,000 clinicians’** and their practices to deliver **better care and result in better health outcomes at lower costs**.
Practice Transformation Networks (PTNs)

Peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation.
PTNs Selected

- Arizona Health-e Connection
- Baptist Health System, Inc.
- Children's Hospital of Orange County
- Colorado Department of Health Care Policy & Financing
- Community Care of North Carolina, Inc.
- Community Health Center Association of Connecticut, Inc.
- Consortium for Southeastern Hypertension Control
- Health Partners Delmarva, LLC
- Iowa Healthcare Collaborative
- Local Initiative Health Authority of Los Angeles County
- Maine Quality Counts
- Mayo Clinic
- National Council for Behavioral Health
- National Rural Accountable Care Consortium
- New Jersey Innovation Institute
- New Jersey Medical & Health Associates dba CarePoint Health
- New York eHealth Collaborative
- New York University School of Medicine
- Pacific Business Group on Health
- PeaceHealth Ketchikan Medical Center
- Rhode Island Quality Institute
- The Trustees of Indiana University
- VHA/UHC Alliance Newco, Inc.
- University of Massachusetts Medical School
- University of Washington
- Vanderbilt University Medical Center
- VHQC
- VHS Valley Health Systems, LLC
- Washington State Department of Health
Key Accountabilities of the PTNs

- Pursue and achieve the quantitative AIMS of the initiative
- Recruit clinicians/practices and build strategic partnerships
- Lead practices in continuous improvement and culture change
- Facilitate improved clinical practice management
- Utilize quality measures and data for improvement
SANs Selected

- American College of Emergency Physicians
- **American College of Physicians, Inc.**
- HCD International, Inc.
- **Patient Centered Primary Care Collaborative**
- **The American Board of Family Medicine, Inc.**
- Network for Regional Healthcare Improvement
- American College of Radiology
- **American Psychiatric Association**
- American Medical Association
- National Nursing Centers Consortium
Key Accountabilities of the SANs

• Pursue and achieve the quantitative AIMS of the initiative.
• Align multiple programs and drivers with aims & activities of TCPI:
  – Continuing Medical Education
  – Maintenance of Certification
  – Registries
  – Journals, Newsletters, Messaging to Members
  – Professional Standards & Requirements
  – Annual Meetings
  – Awards Programs
• Help recruit members into initiative and sustain their active engagement over 4 years
• Support practices with person & family engagement
PCPCC’s SAN Grant

Patient, Caregiver & Community Engagement SAN (PaCCE SAN)

The PaCCE SAN will provide technical assistance to participating practices and networks across the US in order to promote deeper patient relationships and community engagement among care teams.

Four Key Activities

• Unify and communicate key TCPI learnings
• Help define & promote team-based care
• Define & support patient-practice partnerships
• Help define & promote clinic-to-community linkages

Partners & Funding

• Subcontractors:
  – Institute for Patient & Family Centered Care
  – Planetree
  – YMCA of the USA
• Awarded (2015-2019):
  – $566,433 for Y1;
  – $2.9M Years 1-4 (upon CMS renewal each year)
Purpose of the PCPCC SAN

- **WHO:** The Patient, Caregiver, & Community Support and Alignment Network
- **WHAT:** will provide technical support (TA)
- **WHEN:** to participating practices and networks
- **WHERE:** across the US
- **WHY:** in order to establish deeper patient-care team relationships and community engagement
Communicate/Disseminate

• Consensus on practice attributes and metrics for recognition programs
• Successful models of integration across health systems and communities
• Strategies that reduce costs and improve care
  – Messages to all stakeholders
Develop Consensus on Practice Attributes – Defining the “Transformed” Practice

Public: Patients, Families, Caregivers, Consumers

Payers: Employees, Employers, Health plans, Government, Policymakers

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What does alignment across interests look like?

Providers: Primary care teams, specialists, hospitals, community orgs
Promote Team Care

• New staffing models
  – peer support
  – health coaches
  – community health workers

• Fostering team-based care with patients as partners

• Expanded care teams
  – In addition to primary care, adding specialists, Community based organizations (CBOs), social supports
Rethinking Primary Care

Clear communication and effective coordination among health care providers are vital for patient health, but the current primary care structure makes collaboration incredibly difficult. See the difference:

Current Model

- Insurance Company
- Get referral
- Specialist #1
- Schedule blood test
- Follow up with another specialist
- Sends prescription to drug store
- ER Staff

Patient-Centered Medical Home

- Insurance Consult
- Legal Consult
- Behavioral Therapist
- Nurse
- Health Worker
- Primary Care Physician
- Social Worker
- Medical Assistant
- Pharmacist

UCSF Center for Excellence in Primary Care.
Support Patient/Practice Partnerships

• Track and map where partnerships in practice transformation and quality improvement are happening
• Provide training and ongoing support to patient partners
• Disseminate success stories, tools, and resources to foster new and sustainable partnerships
Patient & Family Perspective: Engagement Framework

Levels of engagement:
- Direct care
- Organizational design and governance
- Policy making

Continuum of engagement:
- Consultation: Patients receive information about a diagnosis
- Involvement: Patients are asked about their preferences in treatment plan
- Partnership and shared leadership: Treatment decisions are made based on patients’ preferences, medical evidence, and clinical judgment

Factors influencing engagement:
- Patient: beliefs about patient role, health literacy, education
- Organization: policies and practices, culture
- Society: social norms, regulations, policy

Source: Carman, Dardess, Maurer, Sofaer, Adams, Bechtel, Sweeney (2013) Health Affairs
PCMH includes patients, families & caregivers in practice transformation

- Invite patients/caregivers into quality improvement efforts from the very beginning
- Invite patients/caregivers that represent the larger patient population (i.e. ethnicity, culture)
- Invite patients/caregivers with experience managing their own condition
- Provide compensation for patients/caregiver advisors
- Invite more than one patient, family, caregiver
Promote Clinic-to-Community Linkages

• Gather and disseminate successful collaborations from our community based organization (CBO) partners
• Facilitate communications about TCPI to CBO’s
• Test models of formal partnership and shared accountability for patient populations between clinics and CBO’s
New Community Collaborations

- Community Centers
- Public Health
- Employers
- Schools
- Faith-Based Organizations
- Community Organizations
- Health IT
- Home Health
- Hospital
- Oral health
- Specialty & Subspecialty
- Skilled Nursing Facility
- Mental Health
- Pharmacy
- Patient-Centered Medical Home
- Health Care Delivery Organizations
OUR PARTNERS
INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

www.ipfcc.org
IPFCC Mission and Resources

www.ipfcc.org

Partnership Guidance Resources

Welcome to the Groupsite for PFAC Network.

The PFACNetwork - Patient and Family Advisors and Leaders Network is for anyone interested in the work of patient and family advisory councils and other collaborative efforts in all health care settings. The PFACNetwork is not linked to patients and family members; all health care staff, doctors, and administrative leaders are welcome. Discussions cover topics related to promoting patient and family-centered care in hospitals and other settings, long-term care facilities, and homes.

This site is a meeting place that provides members of PFAC Network with a shared calendar, discussion forums, member profiles, photo gallery, file storage, and more. We encourage you to upload your photo, complete your profile, and participate!

We have a new Help page which contains step-by-step instructions and scenarios to help everyone with the features of this website.

http://pfacnetwork.ipfcc.org/
Educational opportunities for developing and sustaining effective partnerships with patients and families

In-Depth Seminars

International Conferences

Webinars
http://planetree.org/
PLANTREE
The Standard for Patient-Centered Excellence

formula for Success

17 Countries
Over 700 Organizations

Drives Quality across the continuum
- Skilled Nursing Homes
- Home Health Providers
- Acute Care Providers
- Medical Practices
- Behavioral Health
- Hospice Providers
- Independent Living
- Assisted Living Communities

started by 1 patient in 1978
powered by 50,000 voices
over 9,000,000 lives impacted

Accelerates STAFF and PATIENT Satisfaction

Advocates for Change with
- National Quality Forum (NQF)
- Institute of Medicine (IOM)
- World Health Organization (WHO)
- Institute for Healthcare Improvement (IHI)
CONTRIBUTING TO CARE TRANSFORMATION
THE Y’S HEALTHY LIVING FRAMEWORK

To PROMOTE WELLNESS (Primary)
- Personal Training
- Group Exercise
- Adventure Guides
- Youth Sports
- Wellness Centers
- Brain Health
- Diabetes Prevention
- Smoking Cessation
- Falls Prevention
- Blood Pressure Self-Monitoring
- Diabetes Support
- Cardiac Rehab
- Arthritis Management

To REDUCE RISK (Secondary)
- Board Diversification
- Early Childhood and After-School HEPA Standards
- Competencies for CHWs
- Health Navigation
- Childhood Obesity Intervention
- ACO and PCMH Involvement
- Referral Systems

To RECLAIM HEALTH (Tertiary)
- Built Environment
- Access to Fresh Fruits & Veggies
- Safe places for active play
- Tobacco-free Environments
- Access to Care
- Medicare Coverage of Diabetes Prevention
- Payment Reform
- Cancer Disparities

The Y’s Healthy Living Framework

Impacting INDIVIDUALS
Impacting FAMILIES
Impacting ORGANIZATIONS
Impacting COMMUNITIES
Impacting SOCIETY
A CBO-CENTERED VIEW OF OPPORTUNITIES FOR COMMUNITY-INTEGRATED HEALTH

CBO roles in Community Integrated Health

- Evidence-based Programs
- Compliance
- Shared Spaces
- Community Health Navigation
- Healthier Communities Initiatives
NEXT STEPS – GET INVOLVED!!
Send us your practices!

• Send us the names of practices who want to sign-up for participation in a PTN
• Send us the names of practices who have modeled innovations in team-based care
• Send us the names of practices who have active, meaningful partnerships with patients and family/caregivers in quality improvement
• Send us your tools and resources that make all of this happen
Healthcare Communities: The TCPI Portal

- Two access points:
  - TCPI participants
  - General public (no login or registration required)
- Extends reach beyond those directly involved in the work within the communities
- Bright spots and success stories
- Results to demonstrate the work and progress toward TCPI aims
- Resources to support others on the transformation journey
- Ways to connect and get involved
Join us on our Journey

Learn more about TCPI by coming to our next Conference (Nov 11-13\textsuperscript{th}), subscribing to PCPCC emails and/or having your organization join as an Executive Member.

\textit{Sign up today!}

Visit our website for more details:

[www.pcpcc.org](http://www.pcpcc.org)
Disclaimer

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