

Activating Patient Engagement in Care Delivery

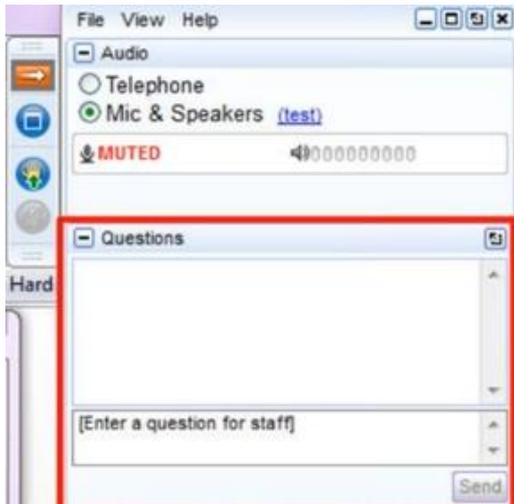
Performance Metrics that Guide Patient-Centered Care (Part 1)

PCPCC Support & Alignment Network
Cambridge Health Alliance

March 22, 2017

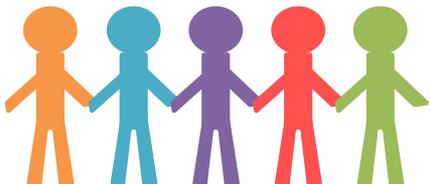


Housekeeping Items



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.



Welcome & Acknowledgements



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Objectives

- Describe three Transforming Clinical Practice (TCPi) 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





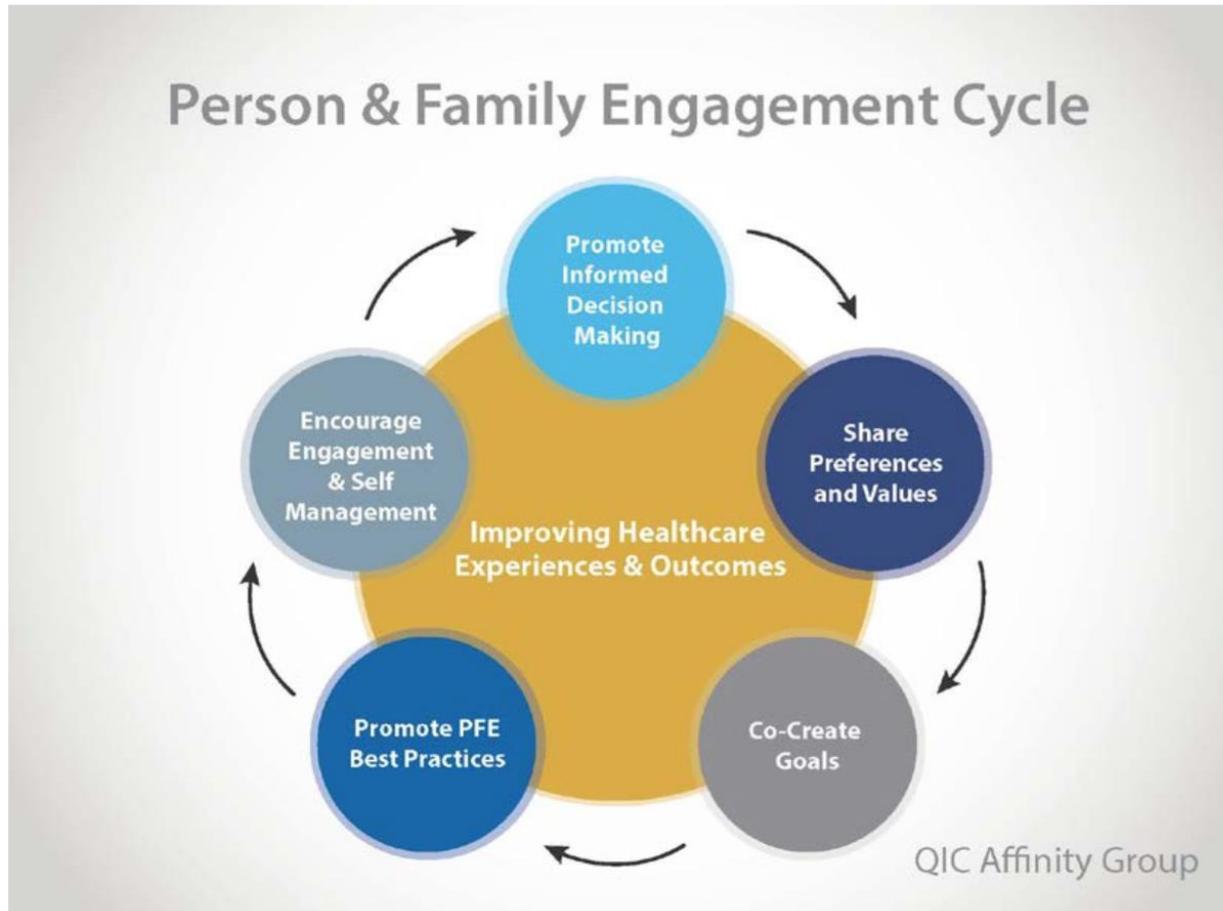
Affordable Care Act

TCPi - 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.



A Strategic Framework



Recent White Paper – Extensive Evidence on PFE



NATIONAL ACADEMY OF MEDICINE
Leadership • Innovation • Impact | for a healthier future

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-



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



Download for free at [NAM.edu/PFEC](https://nam.edu/PFEC)



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?



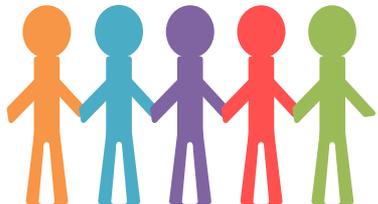
PFE PERFORMANCE METRICS

TCPi | Transforming Clinical
Practice Initiative



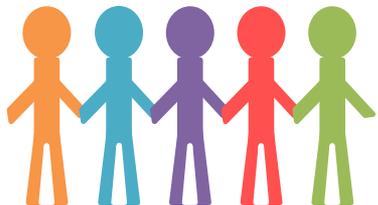
Metric Selection

- 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



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



Person and Family Engagement

Point of Care

- E-tool Use
- **Shared Decision Making**

Policy and Procedure

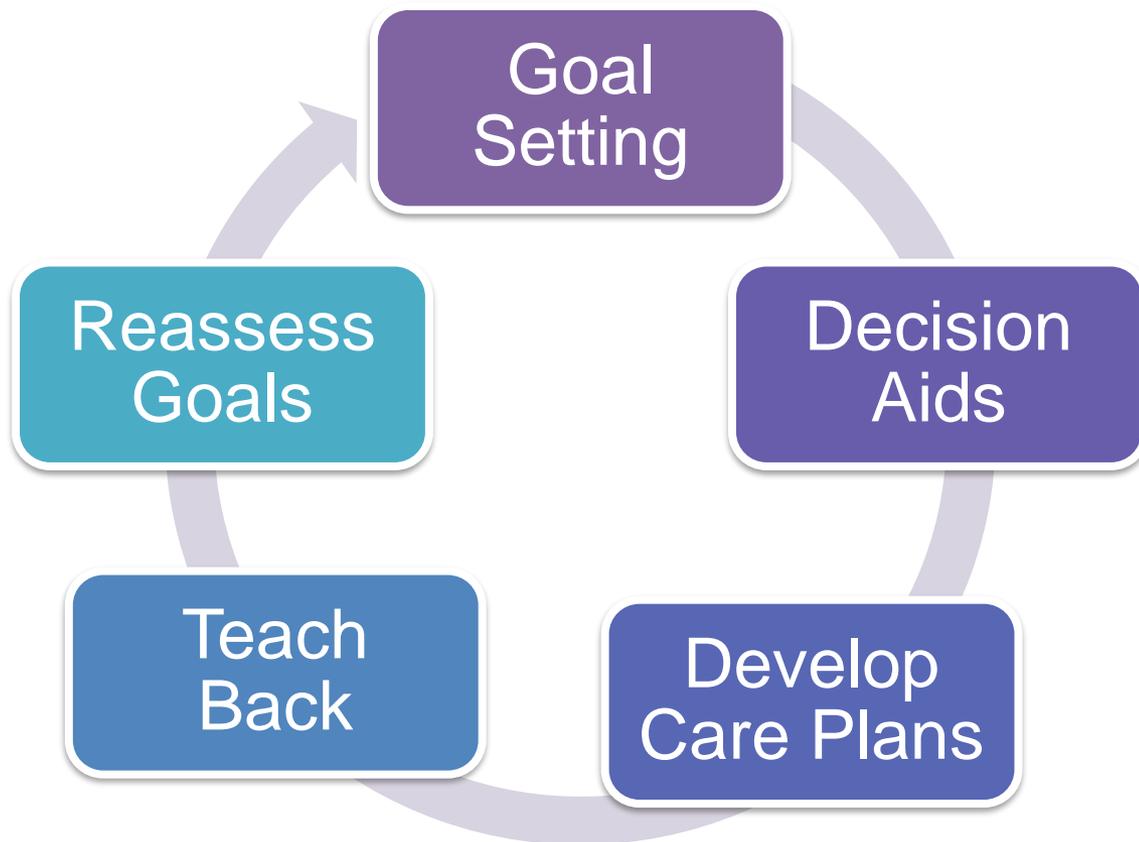
- **Patient Activation**
- **Health Literacy Survey**
- Medication Management

Governance

- Support for Patient and Family Voices



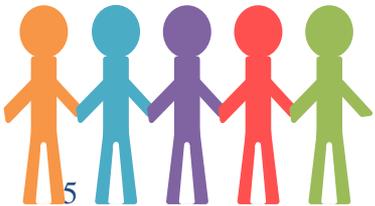
Shared Decision-Making & Self-Management



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.



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.



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".



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.



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.



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.

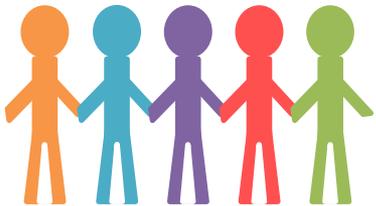
A 2011 analysis of 86 randomized clinical trials concluded that decision aids make patients ***better informed, improve communication with doctors, and increase participation in decisions*** about their care.

Stacey, D., et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev, 2011.



Cambridge Health Alliance

The Story of Partnership



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

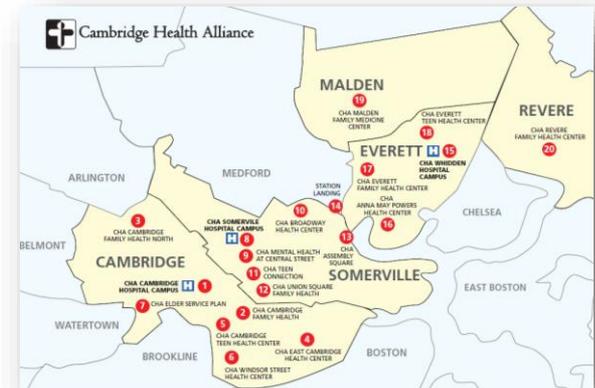
Amberly Ticotsky

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March 22, 2017

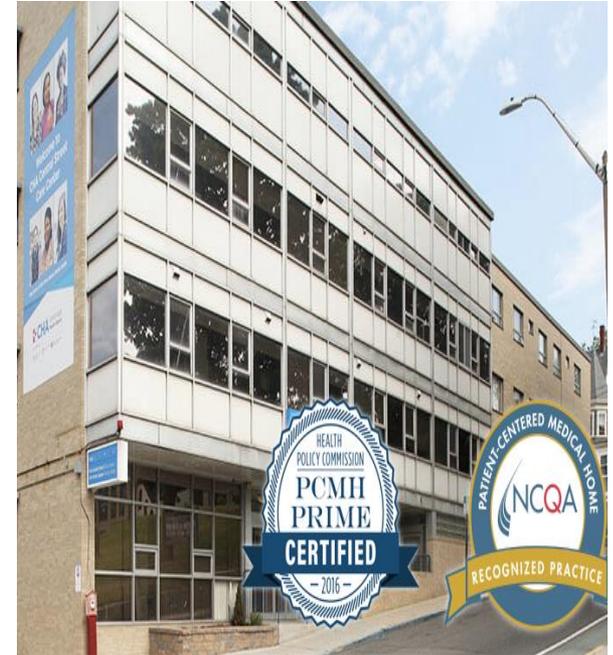
Cambridge Health Alliance

- 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



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



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

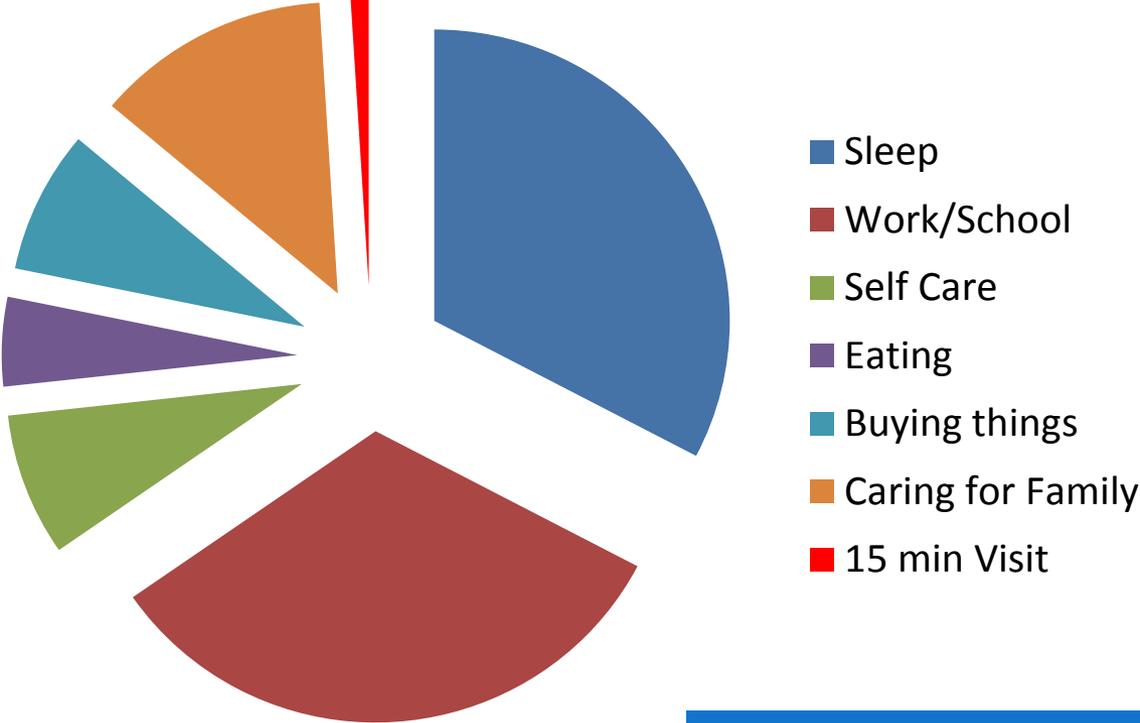


Why Care Plans?

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



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.

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:

- Handouts on: _____
- Picture of plate for healthy eating
- Log for tracking sugars
- Glucometer
- MyChart flow sheet for tracking sugars
- Web sites on: _____
- Name of smartphone app: _____
- 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 _____

Without the pt wants - a thank you card of personal opinion

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:

Asking the right questions:

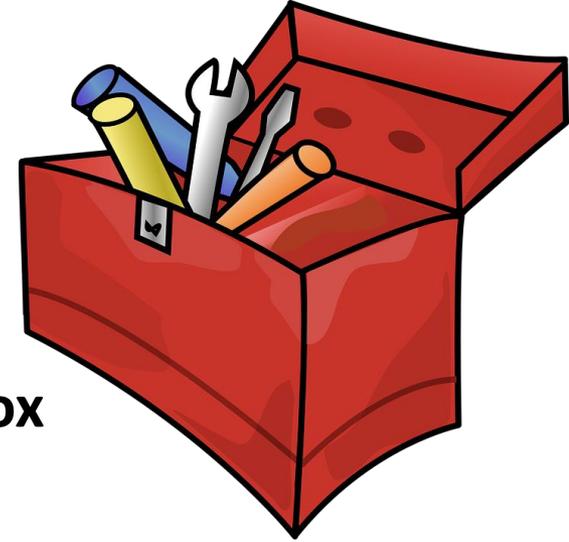


Care Plan Goals

- 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.

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!!

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

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 _____
have agreed that to improve my health I will:

1. 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 activity

What: _____

How much: _____

When: _____

How often: _____

Where: _____

With whom: _____

Start Date: _____

Follow-Up Date: _____

Best Way to Follow-Up: _____

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.

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.”

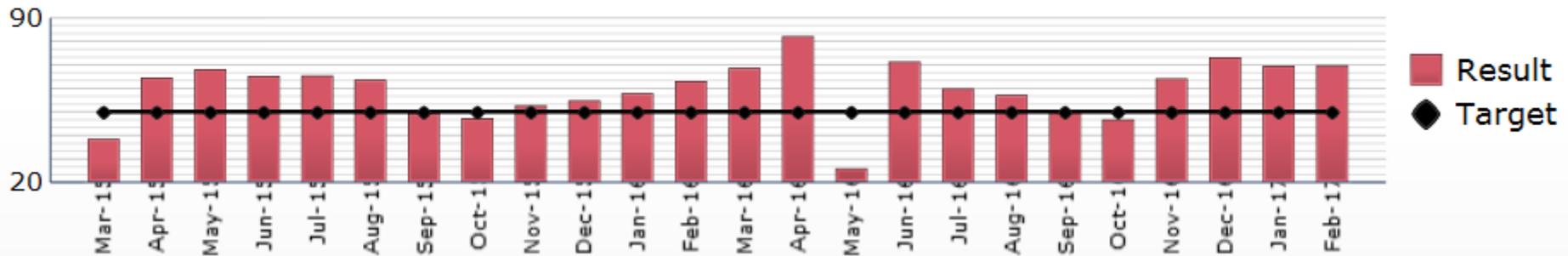
“It’s more collaborative: patient and PCP share the work of putting it together, and the patient leads the process.”

“Patients are more engaged.”

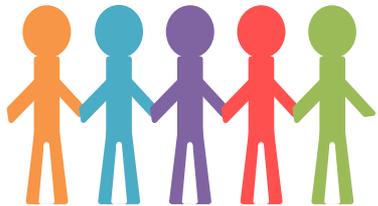
Impact: Patients

- “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...”

History - Depression Care Plan - - SO UNION SQUARE



Resources that support implementation of PFE interventions



AHRQ Shared Decision-Making Resources

The **SHARE** Approach: A Model for Shared Decision Making

The SHARE Approach is a five-step process for shared decision making that includes exploring and comparing the benefits, harms, and risks of each option through meaningful dialogue about what matters most to the patient.



Shared decision making occurs when a health care provider and a patient work together to make a health care decision that is best for the patient. The optimal decision takes into account evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences.



Mayo Clinic Shared Decision-Making Tools

What You Should Know

Will this medicine work for me?

- The antidepressants presented in this decision aid all work the same for treating depression.
- Most people with depression can find one that can make them feel better.
- 6 out of 10 people will feel better with the first antidepressant they try and the rest will have to try other antidepressants before they find the one that is right for them.

Keep in Mind

How: Depression medicines may cause some:

- constipation, diarrhea and nausea
- increased risk of suicidal thoughts and behaviors (18- to 24-year-olds)
- harm to an unborn child
- risk of developing serotonin syndrome, a potentially life-threatening condition
- possible drug-drug interactions

Additional considerations

- Citalopram (Celexa®)** Can cause problems with your heart
- Escitalopram (Lexapro®)** Currently no other issues
- Fluoxetine (Prozac®)** More likely to interact with other drugs you are taking
- Fluvoxamine (Luvox®)** More likely to cause constipation, diarrhea or nausea
- Paroxetine (Paxi®)** Not officially recognized as a treatment for Major Depressive Disorder
- Paroxetine (Paxi®)** If you are pregnant, this medicine is more likely to cause problems with your unborn child
- Sertraline (Zoloft®)** More likely to cause diarrhea
- Desvenlafaxine (Pristiq®)** Tell your doctor if you have high blood pressure
- Duloxetine (Cymbalta®)** Can help with pain
- Duloxetine (Cymbalta®)** Tell your doctor if you have high blood pressure

Weight Change

Some people may experience weight change. It is most likely to occur over six to twelve months and depends on your actual weight. The chart below is based on a 150 lb person.

Weight loss (1 to 5 lbs) ← None → Weight gain (1 to 5 lbs)

Sexual Issues

Some people may experience loss of sexual desire (libido) or loss of ability to reach orgasm because of their antidepressant.

Sleep

Some people may experience sleepiness or insomnia because of their antidepressant.

SNRIs: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline, Desvenlafaxine, Duloxetine, Venlafaxine, Bupropion

SSRIs: Citalopram, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline

Others: None

TCA's: None

Am or N (Elavil®): None

← Insomnia → Sleepiness →

Cost

These figures are estimates and are for comparative reference only. Actual out-of-pocket costs vary over time, by pharmacy, insurance plan coverage, preparation and dosage.

Less ← More

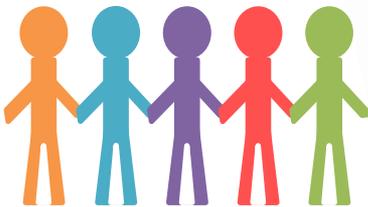
- Citalopram (Celexa®) \$4 / month - Super-stores drug program
- Escitalopram (Lexapro®) \$113 / month - No generic available
- Fluoxetine (Prozac®) \$4 / month - Super-stores drug program

Stopping Approach

Quitting your medicine all at once can make you feel sick, as if you had the flu (e.g. headache, dizziness, light-headedness, nausea or anxiety).

None → More likely → Sick if you skip

- Citalopram (Celexa®)
- Escitalopram (Lexapro®)
- Fluoxetine (Prozac®)
- Fluvoxamine (Luvox®)
- Paroxetine (Paxi®)
- Sertraline (Zoloft®)
- Desvenlafaxine (Pristiq®)
- Duloxetine (Cymbalta®)
- Venlafaxine (Effexor®)
- Bupropion (Wellbutrin®)



Decision Aids - Healthwise



Home > Why Shared Decision Making

SHARED DECISION MAKING EXPLAINED



BENEFITS OF SHARED DECISION MAKING



SDM TRENDS

> Patient Tools Help With Shared Decision-making

Why Shared Decision Making?

1. It is ethically the right thing to do.
2. It is “perfected” informed consent and addresses issues with the current informed consent process.
3. It helps bridge health disparities.
4. It can impact the quality, cost, and safety of health care delivery.

So what is shared decision making?

Shared decision making (SDM) is a collaborative process that allows patients and their providers to make health care decisions together. It takes into account the best clinical evidence available, as well as the patient’s values and preferences.

Shared decision making is not a goal. The goal is better health decisions to achieve outcomes that matter most to the patient. And shared decision making is a way to reach that goal.

A proven process to incorporate the patient’s voice in health care decisions, shared decision making is the pinnacle of patient-centered care.



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


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



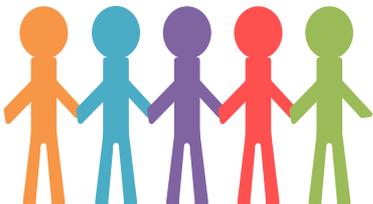

www.insigniahealth.com

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

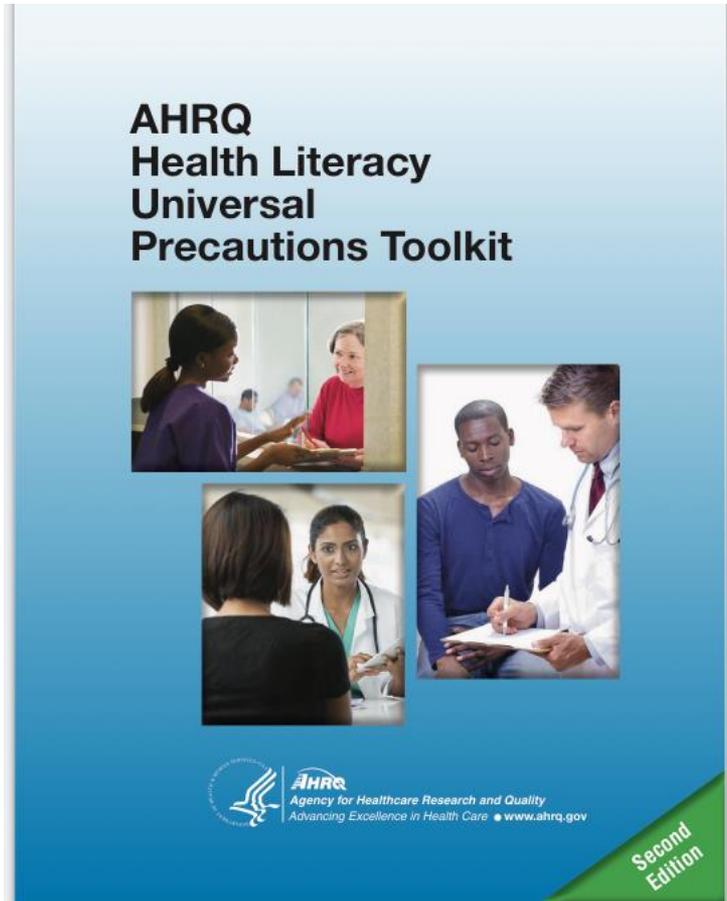
https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/10.1%202011_05_PeaceHealth%27s_Team%20Fillingame_Uses_Patient_Activation_Measures_to_Customize_the_Medical_Home.pdf

Patient Activation – Motivational Interviewing

MODULES	Background
BUILDING THE FOUNDATION	
SPECIALTY PRACTICE RECOGNITION	<div style="display: flex; justify-content: space-around;"> <div style="background-color: #663399; color: white; padding: 5px 15px; border-radius: 3px;">EXPLORE THIS MODULE ▶</div> <div style="border: 1px solid #663399; padding: 5px 15px; border-radius: 3px;">TAKE ACP PRACTICE BIOPSY</div> </div>
IMPROVING CLINICAL CARE	
COLLABORATIVE MEDICATION MANAGEMENT	
DEPRESSION SCREENING & CARE	
MANAGE DIABETES MELLITUS	
IMMUNIZE ADULTS	
CHRONIC PAIN MANAGEMENT	
OPIOID RISK MANAGEMENT	
OSTEOARTHRITIS	
RHEUMATOID ARTHRITIS	
GOUT	
ADDRESSING SUBSTANCE USE	
MOTIVATIONAL INTERVIEWING	<p>Motivational interviewing (MI) can be used as a therapeutic counseling modality for patients with substance use and other disorders. Clinicians can also use the principles of MI more informally in all of their interactions with patients. Common clinical challenges in which MI can be applied include smoking cessation, weight loss, condom use, and adhering to a specific diet, medication regimen, or treatment plan. This section of the module introduces the stages of change upon which MI is built, the core principles of MI, and MI tools.</p> <p>Stages of Change</p> <p>MI grew out of the transtheoretical model of change, which recognizes a series of five steps that individuals typically pass through as they make a significant behavior change. [1, 2] The list below defines the levels and describes the therapeutic goals for each.</p> <ol style="list-style-type: none"> Precontemplation—Individuals in precontemplation often don't recognize the health impact of a behavior and are not seriously contemplating a change. The goal of working with patients in precontemplation is to help them link their behavior to the adverse health risks or consequences they are experiencing. Contemplation—Individuals in contemplation are balancing the pros and cons of maintaining a behavior versus changing it. The goal of working with patients in contemplation is to help them weigh the benefits of a healthy behavior change against the benefits of maintaining the status quo.
ADDRESSING	



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
3	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
	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 .	



Additional Health Literacy Resources



The screenshot shows the website for the NC Program on Health Literacy. At the top, there is a logo with two stylized figures and the text "NC Program on Health Literacy" next to a classical building icon. Below the logo is a row of four photographs: a doctor talking to a patient, a doctor and a woman in a hallway, a close-up of a doctor's face, and two women sitting on a couch. On the left side, there is a dark blue navigation menu with a list of links. The "Teaching Aids" link is highlighted in green. To the right of the menu, the text "Teaching Aids" is displayed in bold, followed by "The Teach Back Method:" and a video player. The video player shows a scene from a video with a man in a white coat and a woman. The video player controls show a play button, a volume icon, a progress bar at 0:00 / 4:45, and icons for closed captions, settings, YouTube, and full screen. Below the video player, there is a link to download the movie in Windows Media format.

- Home
- About Health Literacy
- Program Services Provided
- Literacy Assessment Instruments
- Health Communication Aids
- Quick Start Guides
- ▶ **Teaching Aids**
- Presentations
- Health Literacy Universal Precautions Toolkit
- Contact Us

Teaching Aids

The Teach Back Method:

Teach Back Video--a technique for te...  

0:00 / 4:45   YouTube 

Download movie in Windows Media format [here](#)

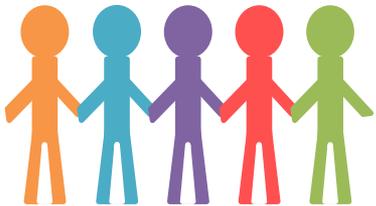


CAPHS Health Literacy Survey - Clinics

- 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

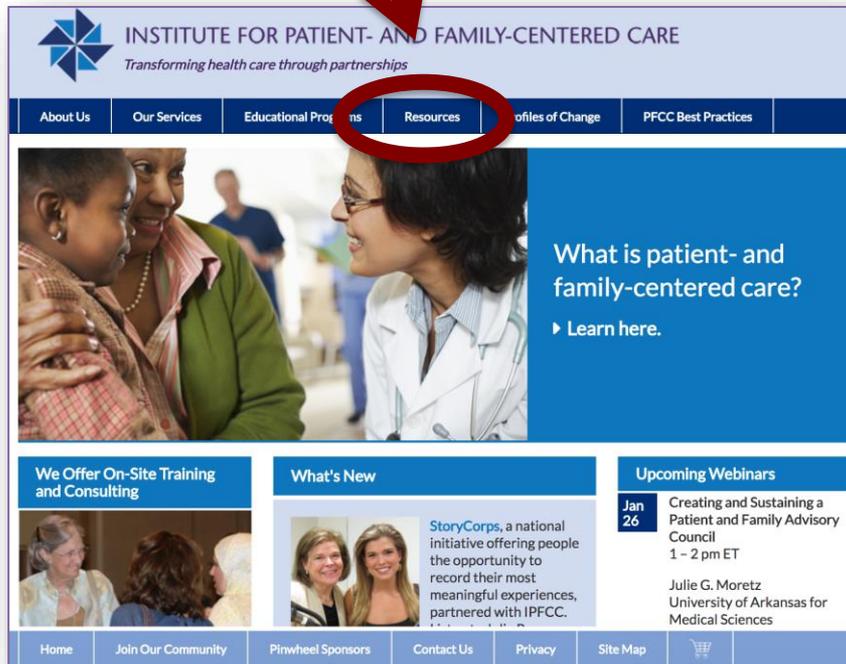


Additional Resources



Institute for Patient and Family Centered Care

Resources



INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
Transforming health care through partnerships

About Us | Our Services | Educational Programs | **Resources** | Profiles of Change | PFCC Best Practices

What is patient- and family-centered care?
▶ Learn here.

We Offer On-Site Training and Consulting

What's New

StoryCorps, a national initiative offering people the opportunity to record their most meaningful experiences, partnered with IPFCC.

Upcoming Webinars

Jan 26 Creating and Sustaining a Patient and Family Advisory Council
1 - 2 pm ET
Julie G. Moretz
University of Arkansas for Medical Sciences

Home | Join Our Community | Pinwheel Sponsors | Contact Us | Privacy | Site Map

Discussion Forums



PFAC Network INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
A SPECIAL THANK YOU TO OUR NETWORK SUPPORTERS

The Children's Hospital of Philadelphia | The Children's Hospital of Philadelphia | Anne Arundel Medical Center | Boston Children's Hospital | Providence HEALTH CARE

HOME | COMMUNICATE | NETWORK | SPECIAL TOPIC GROUPS | MORE INFO | MANAGER | MY SETTINGS | HELP

Discussions
Group Blog
Email Blasts
Chat

Welcome to the site for PFACNetwork.

The PFACNetwork is a forum that brings together those who share a passion for engaging patients and family members in communication, shared decision-making, and institutional collaboration in all areas of health care. The PFACNetwork is a wonderful resource to ask questions, engage in discussion, brainstorm ideas and build relationships with national - and international - peers while working together to promote high quality and safe health care experiences. The PFACNetwork is not limited to patients and family members. All health care staff, clinicians, educators, and administrative leaders as well as community organizers are welcome. Discussion forums cover all topics related to promoting patient- and family-centered care across the health care continuum: clinical care (hospital or medical center, ambulatory care clinic or office, long term care facility, home care); quality improvement and research partnerships; and education of patients, families, staff and students.

Take time to browse the shared calendar, discussion forums, member profiles, photo gallery, file storage and more. We encourage you to upload your photo, complete your profile and participate!

Help Navigating PFACNetwork

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

We also have a new Help Forum which is available to ask questions about website features.

Newsflash

Patient-Centered Primary Care Collaborative (PCPCC) through funding from CMS as part of the Transforming Care Initiative

<http://www.ipfcc.org/>

Join at: pfacnetwork.ipfcc.org



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 to 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?

Contact Us!

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



[**https://www.pcpcc.org/tcp**](https://www.pcpcc.org/tcp)