Patient, Family, and Clinician Partner Training Guide

PCPCC Support & Alignment Network for Patient, Caregiver & Community Engagement
WELCOME

On behalf of the Patient-Centered Primary Care Collaborative Support & Alignment Network, we are thrilled to welcome you to our Patient, Family and Clinician Partner Training. This day is dedicated to providing patient advisors and their clinician partners with the knowledge, tools, and skills required to drive practice transformation in primary and ambulatory care settings.

It is a privilege to have such dedicated patient advisors, community partners, clinicians and other health care professionals join us to learn more about promoting meaningful partnerships in quality improvement and community collaboration with care teams in primary and ambulatory care settings.

Thank you for all you do to advance patient- and family-centered care!

Jacinta Smith, MPH  
SAN Program Manager  
Patient-Centered Primary Care Collaborative

Mary Minniti, BS, CPHQ  
Senior Policy & Program Specialist  
Institute for Patient-and Family-Centered Care

Beverley Johnson  
President & CEO  
Institute for Patient-and Family-Centered Care

Kelly Parent, BS  
Program Specialist for Patient and Family Partnerships  
Institute for Patient-and Family-Centered Care

Suzi Montasir, MPH  
Technical Advisor, Clinical Integration of Chronic Disease Programs  
YMCA of the USA

Tim McNeill, RN, MPH  
Director, Clinical Integration  
YMCA of the USA

Matt Longjohn, MD, MPH  
National Health Officer & Vice President for Evidence-Based Health Interventions and Community Integrated Health  
YMCA of the USA

Jill Harrison, PhD  
Director of Research  
Planetree

Hala Durrah, MTA  
Patient Family Centered Care Advocate & Consultant
Patient, Family, and Clinician Partner Training Agenda
Friday, November 11, 2016
Location: Constitution Ballroom A

7:30 – 8:00 AM
Networking Breakfast

8:00 – 8:20 AM
Welcome & Conference Overview
The training will open with a brief discussion around various session topics from the PCPCC Annual Conference. Participants will also receive a general synopsis of what to expect throughout the training day.

Moderator:
Hala Durrah, MTA, Family Caregiver; Patient Family Centered Care Advocate & Consultant

8:20 – 8:50 AM
The BIG Picture: The Quadruple Aim of Healthcare Reform, the Transforming Clinical Practices Initiative (TCPI), and Why We Need Patient, Family & Community Partners
Participants will be provided with an overview of what is happening in health care reform using the Quadruple Aim as a framework, identify stakeholders among PCPCC membership involved in this movement, and learn about other federal initiatives, including the Transforming Clinical Primary Initiative.

Speaker:
Beverley Johnson, IPFCC CEO & President; PCPCC Board Member

8:50 – 9:10 AM
Role of the PCPCC SAN Grant in Helping Achieve TCPI Goals
The PCPCC, Institute for Patient- and Family-Centered Care (IPFCC), Planetree, and YMCA of the USA have joined forces to form the PCPCC’s Support and Alignment Network (SAN). Primary/ambulatory care practices and enrolled clinicians participating in TCPI have access to technical assistance provided by the PCPCC SAN to help guide practice transformation through patient engagement and quality improvement. In this session, participants will discover the opportunities each organization is offering and how they can benefit from these resources.

Speakers:
Jacinta Smith, MPH, PCPCC SAN Program Manager
Jill Harrison, PhD, Director of Research, Planetree
Matt Longjohn, MD, MPH, National Health Officer & VP for Evidence-Based Health Interventions & Community Integrated Health, YMCA of the USA
Mary Minniti, BS, CPHQ, Senior Policy & Program Specialist, IPFCC

9:10 – 9:40 AM
Break Out Session: Why We Are Here
Participants will 1) identify challenges related to building patient and practice/clinician partnerships and 2) discuss steps that may be taken to strengthen partnerships and improve the quality of care delivery.

Facilitator:
Hala Durrah, MTA, Family Caregiver; Patient Family Centered Care Advocate & Consultant

9:45 – 10:00 AM
Break
Developing Patient and Family Partnerships in Practice Transformation

This session will instruct participants on how to transform primary/ambulatory care practices into high quality and satisfying experiences through partnership with patients and families at the point-of-care and beyond. Expert faculty will share best practices demonstrated across primary/ambulatory care programs and highlight the roles patients and family caregivers can play to improve quality and safety.

Speakers:
Mary Minniti, BS, CPHQ, Senior Policy and Program Specialist, IPFCC
Kelly Parent, BS, Program Specialist for Patient and Family Partnerships, IPFCC

Mechanisms for Establishing Successful Partnerships Between Practices And CBO; The YMCA’s DPP and Other Examples

Our partners from the YMCA will highlight the importance of clinical-integration of clinical practices and community-based organizations (CBOs) as successful partnerships to support patients and achieve practice improvements. Participants will learn about the incentives and roles of the clinical practice and the CBO. Program outcomes from the YMCA’s Diabetes Prevention Program (DPP) and its planned expansion through Medicare will also be discussed.

Speaker:
Tim McNeill, RN, MPH, Director, Clinical Integration, YMCA of the USA

Creating Partnerships Between Practices and Community-Based Organizations

This session will emphasize the importance of bidirectional communications, partnering with patients in the community, promotion and referral to evidence-based programs by practices, and key aspects of shared space arrangements. The YMCA will conclude with a presentation of their vision of Community Integrated Health.

Speaker:
Suzi Montasir, MPH, Technical Advisor, Clinical Integration of Chronic Disease Programs, YMCA of the USA

Changing How We Do EVERYTHING! Moving from FOR Patients and Families to WITH Patients and Families

Participants will examine lessons learned from Planetree Designated organizations and PCORI Engagement Award to Engage Patient and Family Partners. Planetree faculty will share real-world examples to shift organizational culture and practice to prioritize and personalize patient partnerships.

Speaker:
Jill Harrison, PhD, Director of Research, Planetree

Overview of Action Plan and Strategies/Turning Ideas into Action

Participants will receive an instructional overview on completing an action plan that includes ideas and strategies for practices/clinicians to foster partnerships with patients, family caregivers to improve care delivery and quality.

Speakers:
Jacinta Smith, MPH, PCPCC SAN Program Manager
Mary Minniti, BS, CPHQ, Senior Policy and Program Specialist, IPFCC
2:30 – 3:30 PM  
**Turning Ideas into Action**  
Training faculty will be assigned to various teams to help facilitate plan development. Action plans will include priorities for practice improvement based on the Practice Assessment Tool (PAT) and other quality improvement templates.

**Moderators:**  
All training faculty

3:30 – 4:00 PM  
**Closing Summary**  
Expert faculty will join training participants in a discussion summarizing the day’s activities and lessons learned.

**Moderators:**  
**Hala Durrah, MTA,** Family Caregiver; Patient Family Centered Care Advocate & Consultant  
**Jacinta Smith, MPH,** PCPCC SAN Program Manager
The BIG Picture: The Quadruple Aim of Healthcare Reform, the Transforming Clinical Practices Initiative (TCPI), and Why We Need Patient, Family & 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 Quadruple 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.
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.

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.

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


Connecting with the Gun Club...
“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

Results in Marion County

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 enrolled 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.
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.
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.

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.”


2012

Triple Aim — Patient- and Family-Centered Care

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

Don Berwick
June 5, 2012
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." S-5.

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 creates Center for Patient Partnership in Healthcare to advance collaboration between physicians and patients.
In high-functioning health care teams, patients are members of the team; not simply objects of the team’s attention...”

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 planned the "walk and talk series."

Leadership is KEY . . .

The Patient Advisory Council members have been enthusiastic and interested in improving care of patients and outreach 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
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/
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-centered 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 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.

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"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

In Conclusion . . .

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Library
Hospitals & Clinics
Advocacy Organizations
Schools
Grocery Stores
Community Health
Your health
Your Family’s health
Your Health
Health Plans / Insurers
References and Resources (cont’d)


- Homer, C. J., & Baron, R. J. (2010). How to scale up primary care through personal stories, families, and communities. Family Medicine, 42(5), S90-S98.


- Institute for Patient- and Family-Centered Care: www.ipfcc.org.


References and Resources (cont’d)

- Open Notes: www.opennotes.org.
- Patient-Centered Primary Care Collaborative (PCPCC). Primary Care Innovations and PCMH Map: www.pcpcc.org/initiatives.
Key References and Resources (cont’d)


Role of PCPCC SAN Grant in Helping Achieve TCPI Goals

Support & Alignment Network for Patient, Caregiver & Community Engagement
Transforming Clinical Practices Initiative (TCPI)

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

PCPCC SAN FACTS
The PCPCC 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.

Partners
• Institute for Patient & Family Centered Care
• Planetree
• YMCA of the USA

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
PATIENT-CENTERED PRIMARY CARE COLLABORATIVE
Unifying for a better health system - by better investing in team-based patient-centered primary care

PUBLIC:
- Patients
- Families
- Communities

PAYERS:
- Employers
- Government
- Health plans
- Consumers

PUBLIC:
- Patients
- Families
- Caregivers
- Communities

HEALTH CARE PROVIDERS: people who take care of patients/families

Collaborative:
• Convene
• Communicate
• Advocate

NATIONAL IMPERATIVE: "TRIPLE AIM"

"QUADRUPLE AIM"

Better Patient Experience

"Joy in Practice"

Improved Quality (better outcomes)

Lower Per Capita Health Care Costs


"Joy in Practice"
Clinic to Community Linkages to Improve Patient Outcomes

Matt Longjohn, MD, MPH
National Health Officer
VP, Evidence Based Health Interventions
YMCA of the USA

The Changing Health Care Landscape

Past

Acute Health Care System
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

Present

Coordinated Seamless Health Care System
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

Future

Community Integrated Health Care System
- High quality acute care
- Accountable care systems
- Shared financial risk
- Case management and preventive care systems
- Population-based quality and cost performance
- Population-based health outcomes
- Care System integration with community health resources

HHS’s View of Community Based Organizations’ Value in Health Care

IPFCC Training and Technical Assistance in the PCPCC SAN

- Support for Patient and Family Advisors
  - Learn about your role in quality improvement in primary or ambulatory care
  - Network with other advisors across North America
- Support for Health Care Practices
  - Webinars on important partnership topics
  - Peer support technical assistance for development within the practice
- For All:
  - Coaching calls, technical assistance, and virtual support including Storytelling
  - IPFCC Seminar Scholarships

INSTITUTE FOR PATIENT-AND FAMILY-CENTERED CARE

www.ipfcc.org
A Learning Community to promote high quality and safe care in primary care and ambulatory practice through effective partnerships between those who receive care and their families and those who deliver care. A source of information, resources, networking to share tools and strategies as well as a forum to share successes and challenges.

Open to patient and family partners and the practices they work with. To join: http://pfacnetwork.ipfcc.org

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

- Discuss how to transform primary and ambulatory care practices into high quality and satisfying experiences through partnership with patients and families at the point-of-care and at beyond.
- Explore the roles that patient and family advisors can play to improve quality and safety.
- Share best practices demonstrated across primary and ambulatory care programs, their success and challenges.
Scenario A

“Your need to freeze your eggs.

“We need the room for another patient.”

“You are 18 – this is your last visit.”

“You need to freeze your eggs.”

Outcomes of Clinic Visit

Young Adult Patient
- Confused
- Humiliated
- Unimportant
- Closed-mouthed
- “I am done…”

Mom
- Disrespected
- Angry
- Minimized
- Failure
- “We are done…”

“Doctor was only in the room for a couple of minutes.”

Scenarios B & C & D

“…what are the boys like…”

“…why did your mother make you come…”

“…I don’t have anything to add but… I’m a parent, too…”

“…until your old and I’m really old…”

“…what worries you…”

“…why did your mother make you come…”

“…until your old and I’m really old…”

“…what worries you…”
Outcomes of Clinic Visits

Patient
- Felt like a kid not a disease
- Felt reassured
- Felt listened to
- Felt the compassion
- “I liked him/her…”

Mom
- Validated
- Respected
- Hope
- “A good mom”
- “I would recommend…”

“Doctors took all of the time that they needed to take with us.”

In all reality... TIME does not have to be limiting

Scenario A

Scenarios B/C/D

What is Patient- and Family Centered Care?

Partnerships based on Respect & Dignity, Information Sharing, Participation, and Collaboration
Patient- and family-centered care is working "with" patients and families, rather than just doing "to" or "for" them.

Patient- and family-centered care provides the framework and strategies to transform organizational culture and improve the experience of care, and enhance quality, safety, and efficiency.

Transforming Healthcare: A Safety Imperative

"We envisage patients as essential and respected partners in their own care and in the design and execution of all aspects of healthcare. In this new world of healthcare, organizations publicly and consistently affirm the centrality of patient- and family-centered care. They seek out patients, listen to them, hear their stories, are open and honest with them, and take action with them. ... Continued."
The family is respected as part of the care team—never visitors—in every area of the hospital, including the emergency department and the intensive care unit.

Patients share fully in decision-making and are guided on how to self-manage, partner with their clinicians and develop their own care plans. They are spoken to in a way they can understand and are empowered to be in control of their care.

"Transforming Healthcare: A Safety Imperative (cont’d)"

"Engagement, broadly defined, is an active partnership among individuals, families, health care clinicians, staff, and leaders to improve the health of individuals and communities, and to improve the delivery of health care."

Health Affairs, 32(2) 2013

Collaborative patient and family engagement is a strategy for building a patient- and family-centered system of care. It is a priority consideration and essential to health reform at four levels:

- At the clinical encounter—patient and family engagement in direct care, care planning, and decision-making.
- At the practice or organizational level—patient and family engagement in quality improvement and health care redesign.
- At the community level—bringing together community resources with health care organizations, patients, and families.
- At policy levels—locally, regionally, and nationally.
### TCPI AIMs/Goals

**Continuous, Data-Driven Quality Improvement**

**Patient and Family-Centered Care**

**Design**

**Sustainable Business Operations**

### Primary Drivers

1. **1.1 Patient & family engagement**
   - Team-based relationships
2. **1.2 Team-based relationships**
3. **1.3 Population management**
4. **1.4 Practice as a community partner**
5. **1.5 Coordinated care delivery**
6. **1.6 Organized, evidence-based care**
7. **1.7 Enhanced Access**

### Secondary Drivers

3. **3.1 Strategic use of practice revenue**
4. **3.2 Staff vitality and joy in work**
5. **3.3 Capability to analyze and document value**
6. **3.4 Efficiency of operation**

### Drivers: Essential to Achieving TCPI Aims

2. **2.1 Engaged and committed leadership**
   - Quality improvement strategy supporting a culture of quality and safety
2. **2.2 Quality improvement strategy supporting a culture of quality and safety**
3. **2.3 Transparent measurement and monitoring**
4. **2.4 Optimal use of HIT**

**6) Reduced costs:** Practice controls its internal costs as well as other elements of total cost of care.

**7) Documented Value:** Practice can articulate its value proposition and increases participation in available value-based payment agreements.

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### Patient & Family Perceptions and Expectations

Assume **patients** are the experts on their own experience and that they have information you need to hear and act on.

Know that **families** are primary partners in a patient’s experience and health.

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### Change The Assumptions

- Assume patients are the experts on their own experience and that they have information you need to hear and act on.
- Know that families are primary partners in a patient’s experience and health.
### What do Patients and Families Expect...

- To receive high-quality, safe care
- To be present
- To be listened to, taken seriously, and respected as a care partner
- To have full and timely access to medical information
- To have coordination among all members of healthcare team across all settings
- To always be told the truth with full explanations, transparency and apology
- To be supported emotionally as well as physically

#### Support-Comfort-Information-Proximity-Assurance

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<td>Assurance</td>
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### Learning Through Surveys

**e-Advisor Survey, 2014**

**What do families want at clinic appointment?**

- Ample time spent with physician
- Short wait to get to exam room.
- Short wait to see physician.
- Pleasant and helpful greeting.

> "I did appreciate the note on the board stating how far behind the doctor was running. It was a long wait but we appreciated having the heads up."

### Learning Through Surveys

**e-Advisor Survey, 2010**

**What makes an unpleasant clinic appointment?**

- Long waits (over an hour)
- Not being heard
- Lack of follow through
- Repeating story multiple times
- Needing to go to multiple locations to see different people when scheduling surgery
- Unpleasant or rude greeting
- Leaving the clinic with no plan
- Driving a distance only to have minimal time with the physician
What Makes a Positive Check-in Experience?

- Responsive staff who are friendly, pleasant, and sincere (appropriate smile and eye contact)
- Prepared greeter staff who know who you are and why you are there
- Staff that do not make us feel that you are inconvenienced by us.
- Staff who listen to our concerns.
- For pediatric patients, staff who talk to our child and/or are ready with distraction activities.

"First impressions mean a lot."

Partnering with Patients and Families at the Point-of-Care
Seeing the Person Behind the Patient and the Disease

- Who is this person?
- How can I connect with this patient as a person?
- Who are the important people in the person's life?
- How does this person fit into her family, community, world?
- What is important to this person and her family?

Challenges of Patients and Families

- Cognitive
- Emotional
- Social
- Financial
- Spiritual

The Impact of Illness and Injury on Social Identity

- Illness or injury may mean time away from our loved ones.
- Illness or injury may mean that we need to give up activities that we love.
- Illness and injury may mean that we have less in common with old friends.
- Illness or injury may mean that we will connect with people that we may not previously have thought possible.
- Illness or injury may mean that we will not be home for holidays.
Doctor-Patient Communication Gap

Researchers at the Yale School of Medicine asked 89 patients and 43 doctors about the patients’ hospital experiences, and found strikingly different perspectives between the two groups. [Source: Archives of Internal Medicine, Aug 9, 2010]

Presence and Participation
An engaged and informed family leads to better health care outcomes:
- Family observations can improve clinical decision-making
- Families can be allies in preventing medication errors and promoting patient safety
- Continuing presence and familiar roles enhance family well-being, confidence, and competence
  - breeds trust in the healthcare system
  - increases knowledge of patient's true condition
  - High acuity and complex care education takes time

Provider-Family Partnerships Improve Care
Families who reported never or only sometimes feeling like a partner were:
- ~10 times more likely to be dissatisfied with services
- ~4 times more likely not to get needed specialty services
- ~2 to 3 times more likely to have unmet needs for either child or family

Words of Engagement

**Encourage Patient to Speak Up**
- "Tell me more. This is really helpful."
- "What do YOU think caused the problem?"
- "What are YOUR thoughts about how we should address this?"
- "What's worrying you most at this point?"

**Invite Family to Share (with permission)**
- "Would you mind telling me a little about your father? It will help me provide better care to get a sense of him as a person."
- "Please tell me about your mother's routine, so we can help her prepare to go home."

Assessing Education: Self Management

Many studies have shown that the patients “with the skills, ability, and willingness to manage their own health and health care—experience better health outcomes at lower cost.”

- How confident do I feel to manage my health?
- What knowledge do I have about my conditions?
- What skills do I have to do that which is necessary to maintain and improve my health?

Health Policy Brief, Health Affairs, February 14, 2013

For information about the measure: www.insigniahealth.com

Judith Hibbard, Patient Activation Measure, University of Oregon

Peer Support – Lucile Packard Children’s Hospital at Stanford

- Making the most of a clinic visit
- How to schedule multiple appointments
- How to manage medications
- Partnering with healthcare providers
- Coordinating care between Packard and community services
- How to parent in the hospital
- Who’s who on your health care team
- Learning about your child’s health condition
- Effective ways to communicate with care providers
- Understanding legal rights
- Working with the schools

Compliments of Karen Wayman, PhD
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<th>Component/Process</th>
<th>No. of #1 Rankings</th>
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<th>Ranking in Bottom 3</th>
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<td>Information Sharing</td>
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<td>Goal Knowledge of Needs</td>
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<td>8</td>
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<td>Ability to Reach Medical Providers</td>
<td>4</td>
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<td>Access to Medications</td>
<td>2</td>
<td>32</td>
<td>5</td>
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<td>Access to Hospital</td>
<td>2</td>
<td>16</td>
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<tr>
<td>Normal</td>
<td>3</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>2</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Activity/Function</td>
<td>0</td>
<td>0</td>
<td>26</td>
</tr>
</tbody>
</table>
After Discharge…

- What came as a surprise?
  - Exhaustion
  - Balancing life and finding normal
  - Loneliness, isolation and burden of responsibility
  - Expectation that I should be an expert
  - Expenses

- What was your biggest need?
  - Respite, rest
  - Communication and care coordination
  - Confirmation that I was doing things correctly

- What advice do you have?
  - Contact information – who to call and when
  - Supplies available when needed
  - Practice before discharge – write, functional
  - Plan for discharge early in admission and have tools for discharge planning
  - Offer next steps, acknowledge fears
  - Don’t rush the process

Doctors are trained first to diagnose, treat and fix—and second, to comfort, palliate and soothe. The result is a slow loss of vision, an inability to see who and what the person who sent the patient we are to the hospital—under whose care patients, we Orders to love not only who they are, but also what they are, and all that they are at the end.

Dhruv Khullar, MD, MPP, Massachusetts General Hospital and Harvard Medical School

“Breaking bad news is actually a golden opportunity to deepen the patient-doctor relationship…For a doctor to be emotionally available is a tremendous gift for any patient.”

Nila Webster, a stage four lung cancer patient

As Bad as or Worse than Death…

- Bowel and bladder incontinence, cited by about 70%.
- Reliance on a breathing machine, cited by about 70%.
- Inability to get out of bed, cited by about 70%.
- Being confused all the time, cited by about 60%.
- Reliance on a feeding tube, cited by about 55 percent of respondents.
- Needing around-the-clock care, cited by more than 50%.

- Patients may underestimate their abilities to adapt to certain healthcare states.
- The survey also found that a vast majority of respondents said that needing to be at home all day, being in moderate pain all the time, or needing to be in a wheelchair would not be preferable to death.

Rubin, Emily B, MD, et al. States worse than death among hospitalized patients with serious illnesses. JAMA Intern Med. Published online August 01, 2016.
Remember the Caregiver

- Heroism
- Overwhelmed – emotional and financial
- Exhaustion – physical, mental and emotional
- Ambivalence
- New Normal

In Summary

- Be Present in the Moment
- Be a Good Listener
- Align treatment with values, life circumstances and preferences
- Engage patients and family caregivers to self-manage
- Provide follow-up with language, cultural, cognitive or physical accommodations

Your words will replay in our minds for days, years - possibly even a lifetime.

~Mott Dad

How Patient- and Family-Centered is Your Clinic?

- Does your patient education vision, mission, and philosophy reflect the principles of patient- and family-centered care?
- Do you inform patients and families how you expect them to engage in their care? Do you provide checklists?
- Are there systems in place to ensure that patients and families have access to complete, unbiased, and useful information?
- Do educational materials convey respect for families and their pivotal role in promoting health and well-being?
- Do you ensure communication that is understood by those with limited English proficiency, low health literacy and those who are hard of hearing?
- Do patients and families serve as advisors on committees and work groups involved in education efforts?
A Key Lever for Leaders... Putting Patients and Families on the Improvement Team

In a growing number of instances where truly stunning levels of improvement have been achieved...

Leaders of these organizations often cite—putting patients and families in a position of real power and influence, using their wisdom and experience to redesign and improve care systems—as being the single most powerful transformational change in their history.


Patients and Family Advisors

Any role in which those who receive care work together with health care professionals to improve care for everyone. Advisors share insights and perspectives about the experience of care and offer suggestions for change and improvement.
Why Involve Patients and Families as Advisors?

- Bring important perspectives.
- Teach how systems really work.
- Keep staff grounded in reality.
- Inspire and energize staff.
- Lessen the burden on staff to fix the problems... staff do not have to have all the answers.
- Bring connections with the community.
- Offer an opportunity to “give back.”

Qualities and Skills of Successful Patient and Family Advisors

- The ability to share personal experiences in ways that others can learn from them.
- The ability to see the bigger picture.
- Interested in more than one agenda issue.
- The ability to listen and hear other points of view.
- The ability to connect with people.
- A sense of humor.
- Representative of the patients and families served by the hospital and clinics.

Useful Framework for Participation

<table>
<thead>
<tr>
<th>Depth of Engagement</th>
<th>Patients and Family Role</th>
<th>Things to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ad Hoc Input</td>
<td>Survey or Focus</td>
<td>Ensure diversity and representation, validity.</td>
</tr>
<tr>
<td>Structured Consultation</td>
<td>Council or Advisors provides QI input</td>
<td>Early consultant supports partnership model.</td>
</tr>
<tr>
<td>Influence</td>
<td>Bi-annual Review/Consultants to project</td>
<td>Requires reflection on why to participate; requires background/commitment.</td>
</tr>
<tr>
<td>Negotiation</td>
<td>Member of QI Group</td>
<td>Training in QI approach.</td>
</tr>
<tr>
<td>Delegation</td>
<td>Co-Chair of QI Group</td>
<td>High level of expertise in area.</td>
</tr>
<tr>
<td>Advisor Control</td>
<td>Implementer or peer support role</td>
<td>Strong training component, mentoring and compensation.</td>
</tr>
</tbody>
</table>
How Patient-Centered Practices Involve Patients in Quality Improvement

- Surveyed 112 patient-centered medical home clinics in 22 states.
- Nearly all solicited patient feedback.
- Only 32% involved patients as advisors on QI teams or councils.
- Leadership commitment essential.

Han, E., et al. Survey Shows That Fewer Than A Third Of Patient-Centered Medical Home Practices Engage Patients In Quality Improvement Health Affairs, 32, no.2 (2013):368-375

Preparing Clinicians and Staff

- Discuss issues and concerns before advisors join group
- Reassure with confidentiality and selection procedures
- Share stories of benefits of patient and family participation in QI

Preparing Advisors for Quality and Safety Committees

- Provide orientation on the quality improvement (QI) methodology & definitions
- Share project background, especially data
- Discuss current topics & issues relevant to advisor’s first meeting
Preparing Advisors for Quality and Safety Committees (cont.)

- Arrange a **pre-meeting** with the Chair of the committee
- Identify a **mentor** for the advisor who also serves on committee
- Share **tips and tools** developed by experienced advisors
- Provide opportunity to **debrief** first 3 meetings

Preparing Clinicians and Staff

- Provide a **bio sketch of advisor** and a picture
- Foster a **“listen first”** approach
- Encourage an **acronym-free zone**
- Place advisors **strategically close to chair or group facilitator**

Fostering a Successful Beginning: Tips for Staff

- Explain how staff should be involved.
  - The importance of listening.
  - Effective approaches to meeting facilitation.
  - Act on advisors observations and recommendations when appropriate and provide information when not implemented.
- Be open to questions and challenges.
  - Try not to be defensive.
  - Respond/explain when questions are asked.
Executive PFAC Meetings
4 Step Process

1- Staff present on current projects related to patient experience
2- Patient & Family Advisors brainstorm and come up with ideas
3- Ideas are used as projects and programs move forward to incorporate the patients’ perspective
4- Follow-up with Patient & Family Advisors on projects and how their ideas are being used

AVS Subcommittee

- 5 monthly 2-hour meetings
- 7 Patient & Family Advisors,
- Sr. Regional Medical Director,
- Health Educator, Provider Educator
- Program Coordinator
- AVS Data collected for baseline
- Poster created
- Communication plan developed

As a Result...

Patient & Family Advisors presented to leadership, all clinic managers and medical directors, 3 months later the increased issue rate was 29.29%

“This is remarkable work! It shows the power of engaging our patients in quality improvement work as partners.” - Dr. Ben Laflants CMO
Making Information Clearer – Patient Input Makes the Difference!

Patient Advisor: Marc Blanco
Patient Experience Project
• Advisors using IPADs to survey patient and family input in clinic

Other activities:
• Recruiting for another clinic location
• Online Advisory Group

Silver Exchange (Advisory Council)
Recent projects: revision of patient letters, waiting room improvements, logo contest
Collaboration Beyond Advisory Councils

- Invite patients with a chronic condition to participate in a clinic team working on improving educational materials or programs to that population of patients.
- Identify patients new to the clinic to participate in a "photo walk-about" to take pictures of ways the clinic is welcoming and places where the messages could be more positive or where way-finding is confusing.
- Ask patients and family what is one change we could make that would improve your experience? Collect the responses and form a clinic team with advisors to follow-up on suggestions.

Patient/Family Advisors on Committees

The Power of the Parent in the Clinic Patient Satisfaction Results

Patient Satisfaction Results

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Score</th>
<th>N Size</th>
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<tbody>
<tr>
<td>Q1 2013</td>
<td>73.2%</td>
<td>82</td>
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<tr>
<td>Q2 2013</td>
<td>84%</td>
<td>81</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>88.4%</td>
<td>86</td>
</tr>
<tr>
<td>Q4 2013</td>
<td>96.3%</td>
<td>80</td>
</tr>
</tbody>
</table>
Benefits of Advisors on QI Teams

- Health care professionals & staff make fewer assumptions about what patients or families “want”.
- Advisors “see things differently” and ask “why do you do it this way?”
- Advisors challenge what’s possible.
- Advisors offer hope, assistance, and support.

“Trust the Process”
Discussion
Learning from others
– How have you partnered with Patients and Families or how would you like to partner with them?
– Patient and Family Partners: What has been your experience or what are your hopes for working with your health care organizations?
– What are the areas for which you could use advice on how to increase engagement in your clinic?
– Share your best practices.
Mechanisms for Establishing Successful Partnerships between Practices and Community-Based Organizations; YMCA’s DPP and Other Examples

COMMUNITY INTEGRATION
SUPPORTING PATIENTS AND FAMILIES

THE Y AND POPULATION HEALTH: EMERGING TRENDS AND SUPPORT OF PHYSICIAN PAYMENT REFORM EFFORTS

OBJECTIVES
1. PROVIDE A PERSPECTIVE ON THE TRENDS IN POPULATION HEALTH, AND THE ROLE OF THE Y IN HEALTH CARE TRANSFORMATION
2. DISCUSS Y-USA’S INFRASTRUCTURE FOR SUPPORTING CHRONIC DISEASE PREVENTION PROGRAMS.
3. DISCUSS THE EMERGING ROLE OF CBOS IN SUPPORTING CLINICAL PRACTICE CLINICAL IMPROVEMENT ACTIVITIES
4. ANSWER QUESTIONS

TRENDS IN POPULATION HEALTH: THE Y’S CHANGING ROLE
IMPACT OF HEALTH REFORM

- Health reform efforts are shifting the financial incentives from fee-for-service to payment for health outcomes
- Value-Based Payment Contracting
- Alternative Payment Models
- Success in a value-based payment contract requires a progressive population health strategy
- Best practice models of population health align health systems with community-based organizations to synergize efforts to address the health of targeted health risks in the community

COMMUNITY INTEGRATED HEALTH

- Comprehensive population health strategy that integrates health systems, providers, and community-based health promotion programs to address the breadth of health issues facing a population
- Elements of success:
  - Treatment strategies that fully implement primary, secondary, and tertiary prevention strategies
  - Clinical pathways to support placing members in appropriate treatment tracts - based on risk stratification
  - Deployment of evidence-based programs in community settings

THE Y’S PORTFOLIO OF EVIDENCE-BASED (RCT PROVEN) PROGRAMS

- YMCA’s Diabetes Prevention Program
- Enhance Fitness (Arthritis Self-Management)
- LIVESTRONG at the YMCA (Cancer Survivorship)
- Moving For Better Balance (Falls Prevention)
- Blood Pressure Self-Monitoring
- Childhood Obesity Intervention
- Brain Health
- Parkinson’s
- Tobacco Cessation

Building the pool of the 21st century
THE ROLE OF THE Y IN ALTERNATIVE PAYMENT MODELS (APMS)

CLINICAL PATHWAYS SUPPORTING EVIDENCE-BASED PROGRAMS VIA ALTERNATIVE PAYMENT MODELS

• Clinical Pathways that fully implement primary, secondary, and tertiary prevention are essential to success in APMS
• Prevention efforts in community-based settings have increased adherence with sustained disease self-management impacts and are essential to a comprehensive population health strategy
  • Medicare Shared Savings ACO
  • Bundled Payment
  • Oncology Care Model

Y EVIDENCE-BASED PROGRAMS SUPPORTING APMS

• Alternative Payment Models provide financial incentives to achieve cost savings and improve clinical outcomes
• The APM model provides the ability to risk-stratify the target population using clinical indicators and Medicare claims data
• Targeted high-risk beneficiaries are referred to the appropriate primary or secondary prevention program
• YMCA evidence-based programs provide the capacity to implement preventive health strategies that are proven to drive improvement of clinical outcomes and reduction in overall healthcare expenditures
Y EVIDENCE-BASED PROGRAMS INTEGRATED WITH APMS

- Medicare Shared Savings Program
- ACO risk stratification to determine populations at risk for diabetes
- Enrollment in a Y DPP Program
- Achievement of cost savings and clinical outcome improvement in the targeted ACO population
- Cardiac Care / Cardiac Rehab Bundled Payment
- Cardiac Rehab Shared Space
- Blood Pressure Self-Monitoring Program

INTEGRATION WITH APMS (CONT.)

- Oncology Care Model
- LIVESTRONG® at the YMCA
- Improved incentives for improved outcomes for beneficiaries diagnosed with cancer
- Support and Navigation activities
- Comprehensive Joint Replacement Bundled Payment
- Moving For Better Balance Program – supporting knee replacement beneficiaries during days 61 – 90 of a bundled payment episode

SUPPORTING MACRA CLINICAL IMPROVEMENT ACTIVITY REQ.
MACRA – MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT

- Establishes a Merit Incentive Program
- First Performance period begins January 1, 2017
- Provider Reimbursement will be adjusted based on a defined scoring methodology
- Links Provider Payment to Outcomes
- Requires clinical practices to engage in clinical improvement activities
- Practice Transformation efforts support successful participation in MIPS payment model

CLINICAL IMPROVEMENT ACTIVITIES (CIA)

- Practices will be graded based on their performance in each CIA:
  - Expanded Practice Access
  - Population Management
  - Care Coordination
  - Beneficiary Engagement
  - Patient Safety and Practice Assessment
  - Achieving Health Equity
  - Emergency Response and Preparedness
  - Integrated Behavioral and Mental Health

EXAMPLE CLINICAL INTEGRATION PATHWAY SUPPORTING MIPS

- Practice Identification of population that has risk factors for diabetes
- Clinical pathways and E.H.R decision support tools that support provider referral to YMCA evidence-based DPP
- YMCA receipt of referral from provider E.H.R using electronic referral to Y E.H.R (Athena Health)
- Clinical documentation of delivery of DPP services to referred consumer
- YMCA E.H.R used to document services with summary report submitted to the referring provider
PROVIDER INCENTIVES FOR CLINICAL INTEGRATION

- YMCA as preferred community provider of evidence-based programs throughout the broad spectrum of the population supports the achievement of the following clinical improvement activities
  - Population Health
  - Care Coordination
  - Health Equity

Y-USA’S MANAGEMENT SERVICES ORGANIZATION

THE LATEST INNOVATION...

Authorized plan for Y-USA to assume functions of a Management Services Organization (MSO) — providing administrative, business, and technology services to local Ys to enable them to receive third party payment for the delivery of the YMCA’s DPP and other chronic disease prevention programs.

- Payor Engagement
- Contracting
- Account Management
- Marketing
- Provider engagement
- Technology support
- Compliance
- Reporting
- Finance

Contracts with vendors for:
- Technology platform
- Billing / revenue cycle management

"Build" "Buy"
 FUNCTIONS OF THE MSO
Program Delivery
Payor Engagement
Contracting
Account Management
IT Systems
Compliance, Reporting, Finance

Local Y Business Function
Y-USA MSO Business Function

EXAMPLE OF CLINICAL INTEGRATION
YMCA of Greater Charlotte:
• Existing shared space arrangement with a large health system serving their market
  • Health System provides direct medical services and preventive health services to community residents, inside the YMCA
  • Relationship will expand to include a targeted focus of physician referrals to evidence-based prevention programs that are sustained through reimbursement contracts and inclusion in Alternative Payment Models
  • Population Health Strategy includes providing targeted physicians referrals to evidence-based interventions at the YMCA
  • The YMCA will be a participant in the health system clinically integrated health network

SHARED SPACE EXAMPLE
CREATING PARTNERSHIPS BETWEEN PRACTICES AND COMMUNITY-BASED ORGANIZATIONS

SUZI MONTASIR, MPH
TECHNICAL ADVISOR
YMCA OF THE USA

MEASURABLE PROGRESS
UNLIMITED SUPPORT

OBJECTIVES
1. SHARE THE Y’S VISION FOR COMMUNITY INTEGRATED HEALTH
2. DISCUSS TECHNICAL ASSISTANCE PROVIDED TO LOCAL YS TO SUPPORT CLINICAL INTEGRATION
3. PROVIDE EXAMPLES OF HOW YS ARE INTEGRATING WITH HEALTH CARE PARTNERS
4. DESCRIBE HOW TO GET CONNECTED TO YOUR LOCAL Y AND ANSWER YOUR QUESTIONS

THE Y’S VISION FOR COMMUNITY INTEGRATED HEALTH
Critical Social Issues Affecting Our Communities:
• High rates of chronic disease and obesity (child and adult)
• Needs associated with an aging population
• Health inequities among people of different backgrounds

Our Shared Intent:
To improve lifestyle health and health outcomes in the U.S., the Y will help lead the transformation of health and health care from a system largely focused on treatment of illnesses to a collaborative community approach that elevates well-being, prevention, and health maintenance.

Our Desired Outcomes:
People achieve their personal health and well-being goals
People reduce the common risk factors associated with chronic disease
The healthy choice is the easy, accessible and affordable choice, especially in communities with the greatest health disparities
Ys emphasize prevention for all people, whether they are healthy, at-risk or reclaiming their health
Ys partner with the key stakeholders who influence health and well-being

COMMUNITY INTEGRATED HEALTH

75% OF U.S. HOUSEHOLDS ARE WITHIN 10 MILES OF A YMCA
Y-USA SUPPORT FOR CLINICAL INTEGRATION

TA PATHWAY TO SUPPORT CLINICAL INTEGRATION EFFORTS AT LOCAL YS

- Y-USA Survey/Screener Tool
- Local Y Strategic Plan
- Partner Community Needs Assessment
- Alternative Payment Model opportunities

Information Gathering
- Conference call or face-to-face meeting

Information Sharing
- Local Y develops Value Proposition
- Y-USA helps local Y develop/define different pathways for partnership

Strategy Development
- Test and refine strategies

ACTION

CLINICAL INTEGRATION IN ACTION
SHARED SPACE EXAMPLES

YMCA of Greater Grand Rapids (Grand Rapids, MI)
- Through partnership with a rehabilitation hospital, new Y built to meet Universal Design standards (intentional considerations to form and function to allow highest degree of accessibility).
- Able-bodied individuals and persons with disabilities are united under the pursuit of fully accessible sports, fitness, and general well-being.

YMCA of the Pikes Peak Region (Colorado Springs, CO)
- Partnership with local health system to build a new medical facility co-located with the Y.
- Services include: primary care, urgent care, occupational medicine, imaging, physical therapy, palliation, women's services, behavioral health, & child watch.

Greater Naples YMCA (Naples, FL)
- New Y facility built in partnership with multiple health care partners.
- Services include: educational support for parents of children with special needs, early education programs, pediatrics, therapy (PT/OT/psychological), & child watch.

REFERRAL DEVELOPMENT

THE Y'S PORTFOLIO OF EVIDENCE-BASED (RCT PROVEN) PROGRAMS

YMCA's Diabetes Prevention Program
Enhance Fitness (Arthritis Self-Management)
LIVESTRONG at the YMCA (Cancer Survivorship)
Moving For Better Balance (Falls Prevention)
Blood Pressure Self-Monitoring
Childhood Obesity Intervention
Brain Health
Parkinson's
Tobacco Cessation

Building the pool of the 21st century
SIMPLIFYING THE REFERRAL PROCESS

Build it into the workflow

- Point of care
- Retrospective
- Electronic
- Feedback loop

Referral Sources

- Health care provider: 29.60%
- Marketing materials: 29.40%
- Staff member: 10.50%
- Family/friend or word of mouth: 10.50%
- Screening event or health fair: 6.90%
- Employer: 2.70%

RECRUITMENT PARTNERS

It takes a village:

- Health care systems and physicians
- Senior centers
- Community organizations
- Health plans
- Faith-based organizations
- Media

17% yield from health care referrals
TYPES OF REFERRALS

• Indirect referral at point-of-care
  - Marketing collateral provided by Y at clinic
  - Up to patient to follow through with referral and contact local Y

• Direct referral at point-of-care
  - Typically facilitated by a health care provider champion
  - Clinician must obtain consent from patient to share info with local Y
  - Marketing collateral provided by Y - promoted/shared in clinic
  - Secure transmission of referral form for each patient

TYPES OF REFERRALS, CONTINUED

• Retrospective query
  - Often facilitated by non-clinical team members (e.g., care coordinator)
  - Targeted communication developed collaboratively (letter, call, etc.) between practice and local Y
  - Next step outlined in communication
  - Successful strategy during YMCA’s Diabetes Prevention Program CMMI Project

• Track/evaluate referral process

LOOKING AHEAD: HOW THIS WILL BE ACHIEVED IN THE Y

Ys will use a single instance electronic medical record system provided by Athena Health to track participant outcomes and ease the burden of the referral on the health care provider.

The system will also allow for a transfer of information back into the health care provider’s record.
LOCATING YS PROVIDING EVIDENCE-BASED HEALTH INTERVENTIONS

- Systems being refined for some evidence-based health intervention public listings (e.g., Moving for Better Balance, Blood Pressure Self-Monitoring, & Healthy Weight and Your Child).
- However, you can find your local Y via http://www.ymca.net/find-your-y or identify contacts for the following programs, directly:
  - Livestrong® at the YMCA (cancer survivorship): www.livestrong.org/ymca
  - Enhance®Fitness (arthritis self-management & falls prevention): www.projectenhance.org
- QUESTIONS?
Changing How We Do EVERYTHING! Moving from FOR Patients and Families to WITH Patients and Families

Need list of members
Planetree
www.planetree.org
+1 (203) 732-1365

The beginning of a “quiet revolution”
As a patient I rebelled against being denied my humanity and that rebellion led to the beginnings of Planetree. We should all demand to be treated as competent adults, and take an active part in our healing. We have the right to heal in care settings meeting our human need for respect, control, warm and supportive care... a truly healing environment.

- Angelica Thieriot

What if patients re-designed the healthcare system?
Defining **CHARACTERISTICS** of the criteria

- Integrated
  - Not setting specific

- Universal in Concept
  - International set developed to accommodate cultural nuances

- Directive, Not Prescriptive
  - Examples and prompts
  - Supportive of innovative and customized solutions

---

**MILESTONES** to target along the way

- Bronze Recognition
  - Meaningful Progress

- Silver Recognition
  - Significant Advancement

- Gold Designation
  - Excellence
Raising the Bar with Planetree Designation

Staff training and support

II.A. Staff participation in experiential patient-centered immersion program
II.B. Care for the caregiver plan
II.G. Practice self-valuation survey
II.H. Patient-centeredness embedded into human resource systems
II.J. Practice staff satisfaction survey

Promotion of authentic, trusting relationships

II.C. Care provided with gentleness
II.D. Users of space involved in office and clinical design efforts

Healing Environment

VI.F. The environment accommodates privacy needs and provides for patient dignity and modesty.

“Care of a disease may be entirely impersonal; the care of the patient must be completely personal. The clinical picture is not just a photograph of a person in bed; it is an impressionistic painting of the person surrounded by his home, his work, his friends, his joys, his sorrows, hopes and fears.”

Francis Peabody, MD, Care of the Patient, JAMA, 1927

The REAL WORLD: the intersection between best intentions and reality....
What it can feel like...

repairing the wing of a plane as it is flying...

Documenting Patient Encounters: TOGETHER

The question that does not ENGAGE patients:
“Do you understand your plan of care?”
“Action is the proper fruit of knowledge.” English Proverb

Your Assignment

• What did you learn or hear about today that excites you?
• What action might you take in the next:
  – Two weeks,
  – Month or two, or
  – Six months
to expand partnerships with patients and families (or with your clinic) to help improve safety, quality and the experience of care.
Helping Clinicians Improve Care: The Transforming Clinical Practice Initiative (TCPI)

With support from the Centers for Medicare and Medicaid Services (CMS), the Transforming Clinical Practice Initiative (TCPI) is designed to assist more than 140,000 clinician practices from 2015-2019 in sharing, adapting and further developing comprehensive quality improvement strategies. This is the largest investment by the federal government in clinical transformation support with $685 million in funding allocated to 39 national and regional collaborative healthcare transformation networks and supporting organizations.

Peer-based Learning: 29 Practice Transformation Networks (PTNs) will provide technical assistance and peer-level support to assist clinicians in delivering care in a patient-centric and efficient manner. Examples include providing dedicated coaches to better manage chronic diseases, supporting patient access to practitioners through email and information technology applications, and helping improve access to remote and virtual care.

Sharing Best Practices: 10 Support and Alignment Networks (SANs) will support the PTNs by providing a system for workforce development and additional assistance with practice transformation. Examples include facilitating patient/family partnerships in quality improvement and practice transformation; a family medicine network to provide coaching, certification and education opportunities; and creating collaborations between primary care and behavioral health clinicians to better address mental health, substance abuse, health behaviors and other environmental stressors.

To learn more about TCPI, visit the TCPI Healthcare Communities Portal: http://www.healthcarecommunities.org.

PCPCC’s Support & Alignment Network for Patient, Caregiver & Community Engagement

The Patient-Centered Primary Care Collaborative (PCPCC; www.pcpcc.org) 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. As a TCPI awardee, PCPCC will support practice improvement teams using our diverse network (representing clinicians, health plans, patients/families, researchers, & policymakers) to foster partnerships with patients, family caregivers and community-based organizations and achieve common goals of improved care, better health, and reduced costs.

Through our Support and Alignment Network (SAN), PCPCC will provide technical assistance to participating practices and networks to promote patient partnerships in quality improvement and community collaboration with care teams to help clinicians meet TCPI’s phases of transformation.

To learn more about our SAN, visit https://pcpcc.org/tcpi or contact Jacinta Smith at jacinta@pcpcc.org.

PCPCC’s SAN Grant Partners

The Institute for Patient- and Family-Centered Care (IPFCC): IPFCC will expand its existing online forum for patient/family advisors, assist in identifying best practices, provide stories about partnering with patient and family advisors in primary care improvement and transformation, and develop an orientation and training for successful partnerships.

Planetree: 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 of the USA: YMCA of the USA will advance a model of community-integrated health in which they will promote clinic-to-community linkages to help patients improve self-management of chronic conditions using evidence-based programs and peer support and test new models of collaboration between clinicians and community-based organizations where an expanded care team will jointly share accountability for a designated patient population.

Sharing Best Practices: PCPCC’s Network for Patient, Caregiver & Community Engagement

Disseminate successful strategies for practice transformation. PCPCC will work with its member organizations to connect practices to the TCPI, communicate key TCPI learnings, and develop coordinated strategies to address transformation challenges faced by clinicians. Based on the evidence derived through the TCPI, the PCPCC Support & Alignment Network (SAN) will:

- Disseminate practice attributes and metrics that demonstrate effective team-based care and patient/family-centered care to inform practice recognition and certification programs.
- Share successful models of primary care integration among specialty care, physician and hospital networks (including ACOs), and within communities.
- Communicate specific strategies that reduce costs and improve care quality among patient populations to a wide range of stakeholders including policymakers, purchasers and consumers.

Promote team-based care models that include patients and caregivers. Building on both evidence-based practices and innovative collaborations, PCPCC will promote strategies that result in comprehensive, team-based care that includes patients and families as meaningful partners on the team. The PCPCC SAN will:

- Disseminate tools and resources to assist in developing new staffing models that include roles for providing peer support in chronic condition management.
- Share strategies for promoting team-based care environments that foster patient and family caregiver inclusion and participation on the care team.
- Together with YMCAs and other community organizations, develop models that provide opportunities to incorporate staff from community-based organizations onto the care team.

Promote and support patient-practice partnerships. PCPCC will connect participating practices with ample support to ensure successful partnership with patients and family caregivers in clinical transformation efforts. The PCPCC SAN will:

- Track and map where clinicians have successfully engaged patients and/or family caregivers in care delivery redesign and ongoing quality improvement efforts.
- Provide training and ongoing support to patients and family caregivers participating in practice-based quality improvement activities.
- Disseminate successful stories and tools to assist clinicians in developing effective partnerships with patients and family caregivers in practice transformation.

Promote clinic-to-community linkages. PCPCC aims to help establish partnerships with community-based organizations (CBOs) offering evidence-based health management programs in their communities. The PCPCC SAN will:

- Gather and disseminate successful models of community-clinic collaborations from organizations such as YMCA, Meals on Wheels, National Council on Aging, etc.
- Facilitate communications about TCPI activities among CBOs in participating communities.
- Develop template agreements and/or best practices on ways in which clinics and local CBOs can share accountability for promoting health for defined populations within a community.