

Aligning for Action

LAN SUMMIT

Health Care Payment Learning & Action Network

**Person and Family
Engagement: Patients as the
Ultimate Value Proposition**

Welcome & Framing

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CMS



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DMI Team



Purpose Today

- **Demonstrate** how Person/Patient and Family Engagement (PFE) contributes to APM goals of driving better care, lower cost and healthier communities
- **Celebrate** the role of PFE in saving lives, reducing costs and readmissions, and reducing hospital acquired conditions during the Partnership for Patients (PfP) Campaign!
- **Show** how the TCPI Community is building on PfP success to adapt, expand and apply PFE strategies and metrics
- **Set/Share a goal** for the TCPI community to surface results that will show at least 50% of the TCPI clinical network achieving at least 3 of the TCPI PFE metrics by June 2017
- **Engage** the TCPI community to produce early PFE results by Quality Conference 2016

Who is in the Room?

Person/Beneficiary Engagement in MACRA Final Rule

Merit-Based Incentive Payment System (MIPS)

Quality = 60% of MIPS Composite Score

- *Care Coordination, medication management, prevention and wellness*

Advancing Care Information = 25%

- *Patient education, medication reconciliation*

Clinical Practice Improvement = 15%

- *Beneficiary engagement, care coordination, patient safety*

Alternative Payment Models (APM)

Medical Home and Medicaid Medical Home models include these components:

- *Patient and caregiver engagement*
- *Shared decision-making*

Person and Family Engagement: Patients as the Ultimate Value Proposition



Mary Minniti, CPHQ
Institute for Patient and Family Centered Care
TCPI PFE Affinity Group

Partnership for Patients (PfP) Initiative Interim Results (through 2014)

87,000 lives saved

***2.1 million fewer Hospital Acquired
Conditions***

***\$19.8 billion savings in healthcare
costs***

Agency for Healthcare Research and Quality: *Saving Lives and Saving Money: Hospital-Acquired Conditions Update*
<http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html>

PfP: Catalyzing Change with HENs and HIINs

- 16 Hospital Improvement Innovation Networks (HIINs) in action now
- Building on 2012-2016 successes of the Hospital Engagement Networks (HENs)

The screenshot shows the website for the Partnership for Patients, a joint initiative of the Centers for Medicare & Medicaid Services. The page features a navigation bar with tabs for Medicare, Medicaid/CHIP, Medicare/Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area includes a 'Welcome to the Partnership for Patients' header with a photo of a patient and a caregiver. Below this, there are sections for 'Goals of the Partnership' (listing a 20% reduction in all-cause patient harm and a 12% reduction in 30-day readmissions), 'Hospital Improvement Innovation Networks' (16 organizations working with over 4,000 hospitals), 'Community-based Care Transitions Program' (34 organizations), and 'Patient & family engagement'.

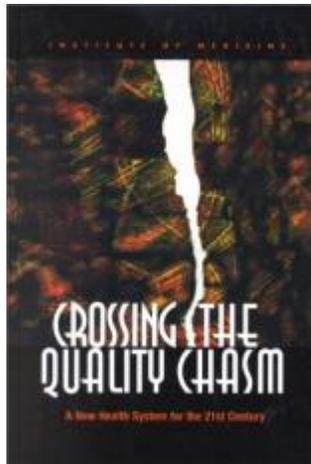
2016 Sammie Award Winners PfP Leadership Honored!



Dennis Wagner
Jean Moody- Williams
Paul McGann

<https://vimeo.com/183322396>

How We Got to Now.....



2001



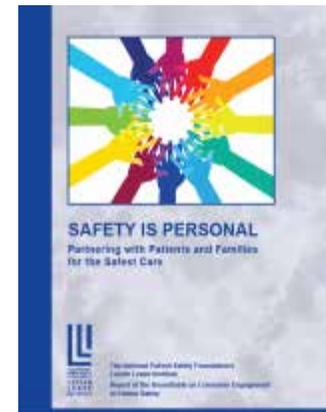
Transforming healthcare: a safety imperative
2009



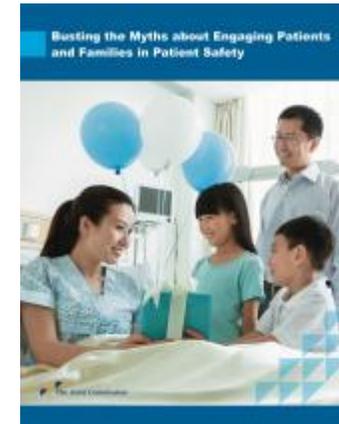
How to scale up primary care transformation: What We Know and What We Need to Know
2010



2013



2014



2016

What is Person and Family-Centered Care?



An approach to the planning, delivery, and evaluation of health care that is grounded in **mutually beneficial partnerships** among health care providers, patients, and families.

It redefines the relationships in health care by placing an emphasis on **collaborating** with people of all ages, at all levels of care, and in all health care settings.

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 the *primary partners* in a patient's experience and health.



INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

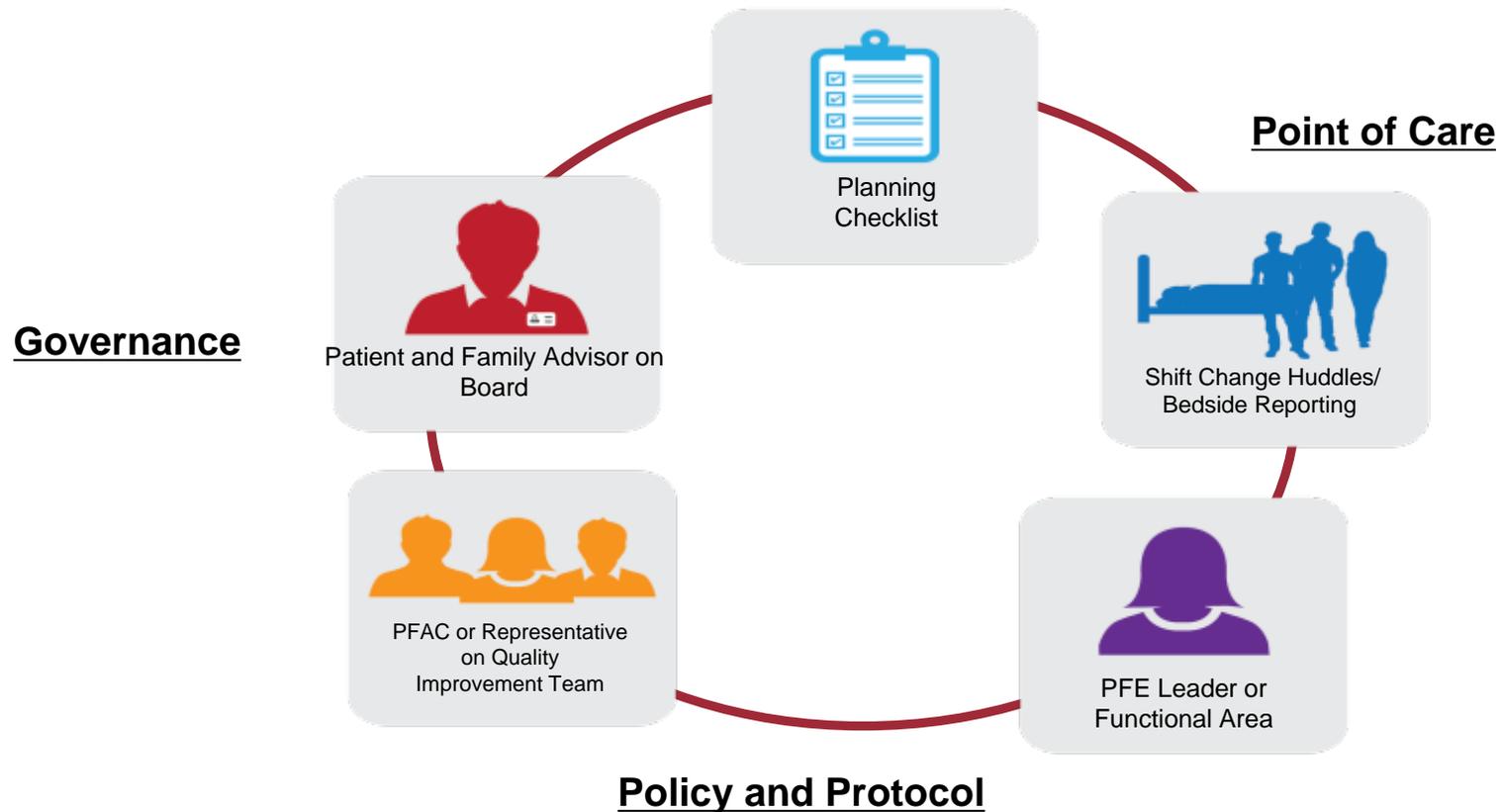
PFE at Multiple Levels

- ∅ 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.

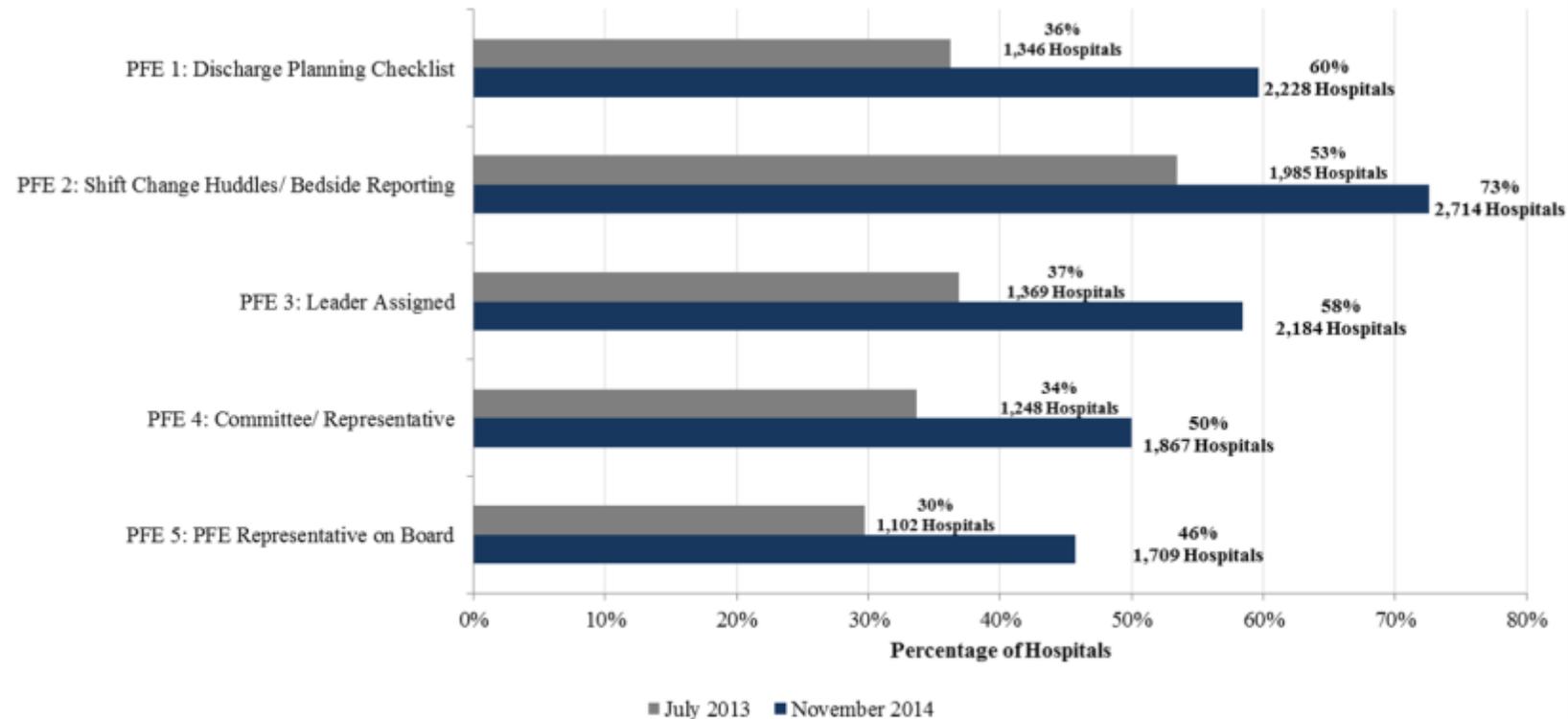


INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

PFE in the PfP Campaign: 5 Metrics of Accelerating Improvement

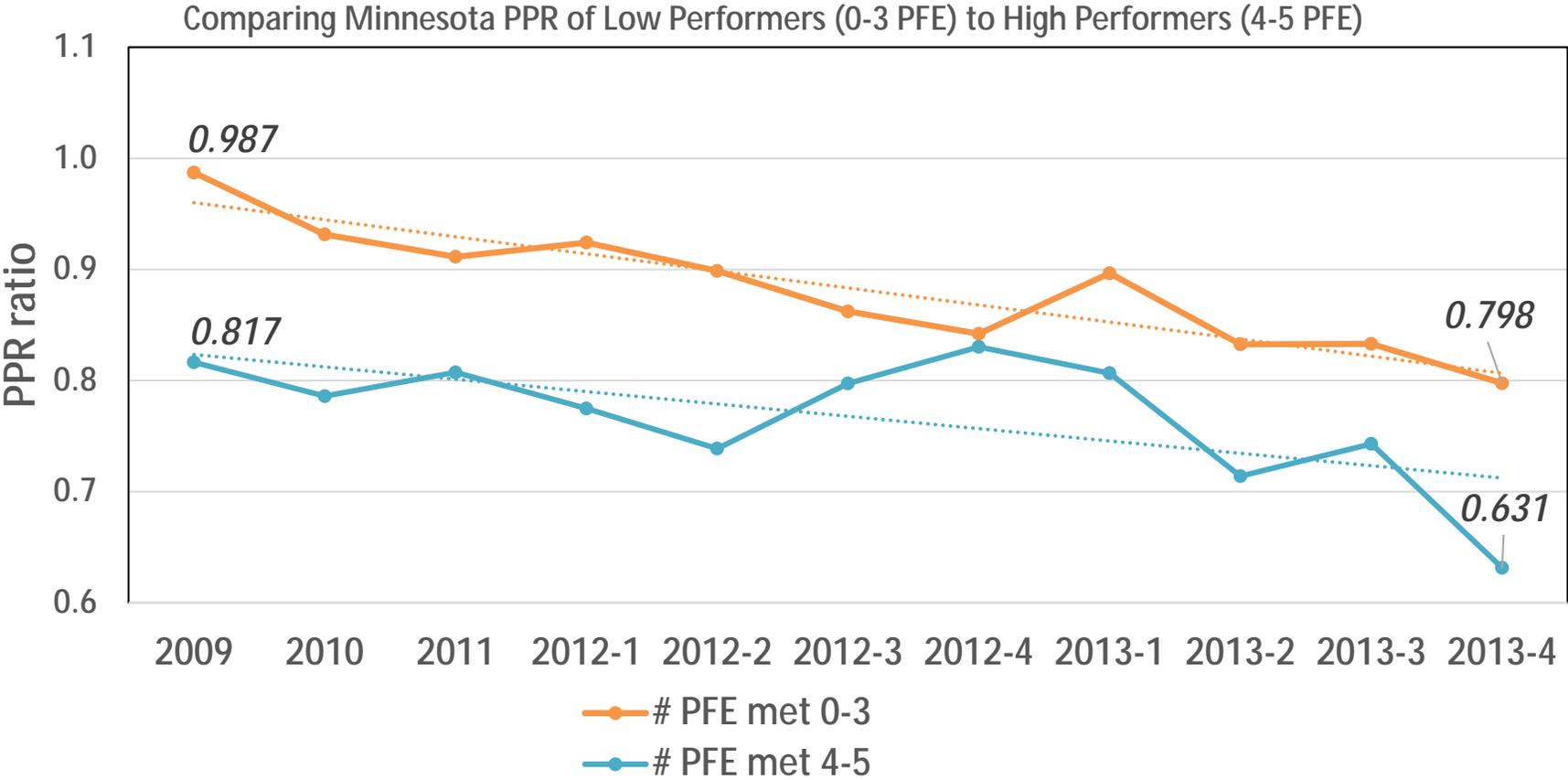


PfP Participating Hospitals PFE Metrics, Jul 2013 – Nov 2014



Source: HEN-submitted Z-5 spreadsheets July 2013 and November 2014.

Minnesota HEN “Pattern” PFE and PfP Campaign Outcomes

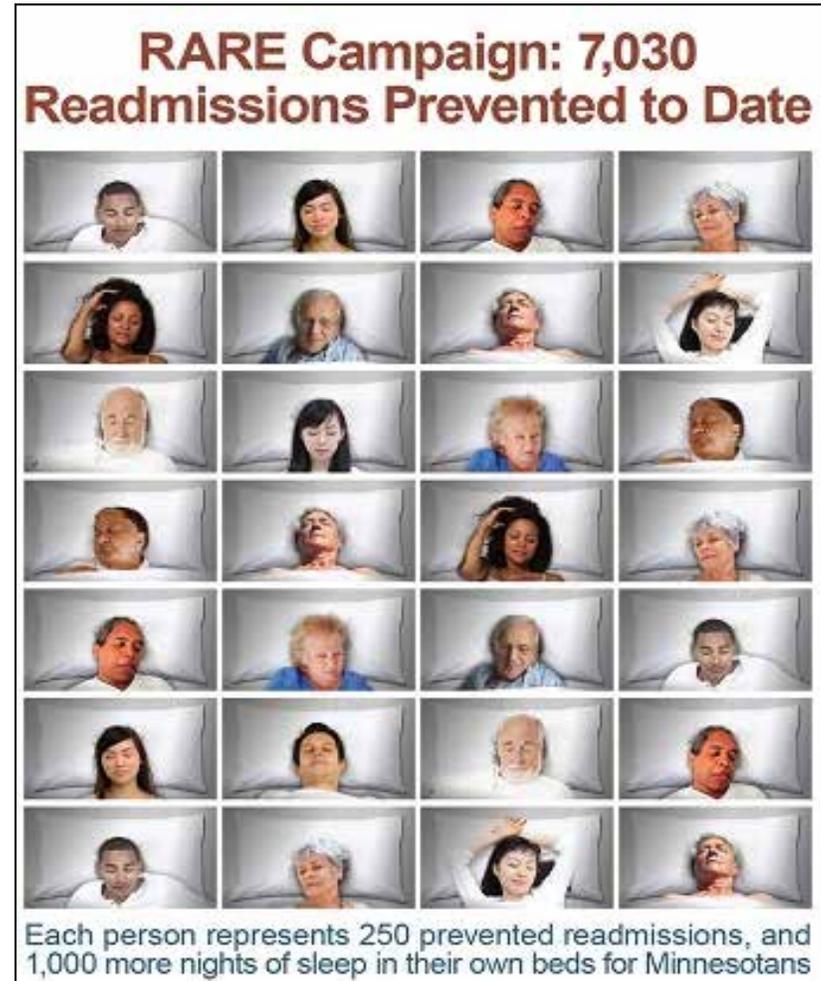


RARE: Reducing Avoidable Readmissions Effectively in Minnesota

Partnership: HEN, QIO, Improvement Experts, and Patients

Results:

- 7,030 readmissions avoided!
- Helped patients spend 24,844 more nights sleeping in their own beds!
- Reduced inpatient costs by an estimated \$55 million!
- Won 2013 John M. Eisenberg Award for Innovation in Patient Safety and Quality!



Mobilizing and Aligning Across a Diverse Network

Healthcare Providers

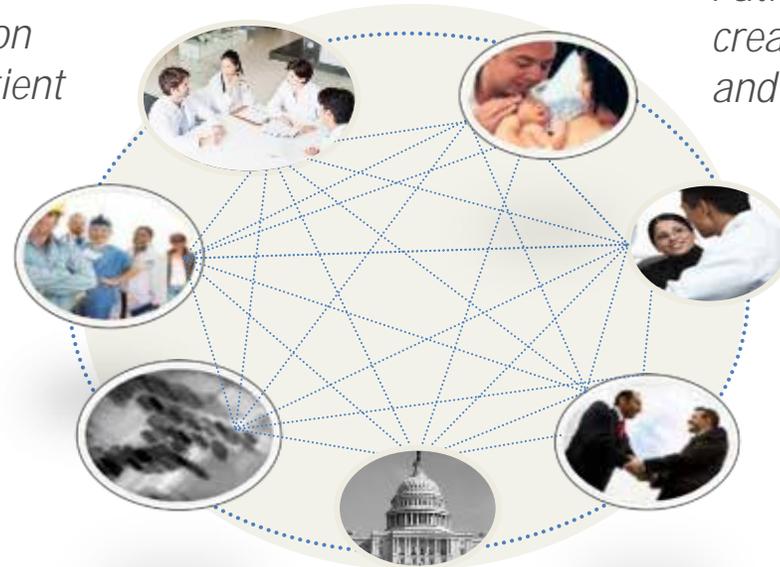
Practice evidence-based medicine and rely on data in making patient decisions

HIINs and Hospitals

Are on the front lines of patient care and patient engagement

Quality Leaders

Set the standard for how patients and families receive care



Patients and Families

Play the most vital role in Patient and Family Engagement, creating a path to better care and conversation

Non-profit and Advocacy Organizations

Provide ongoing support for key programs, activities for patients and families

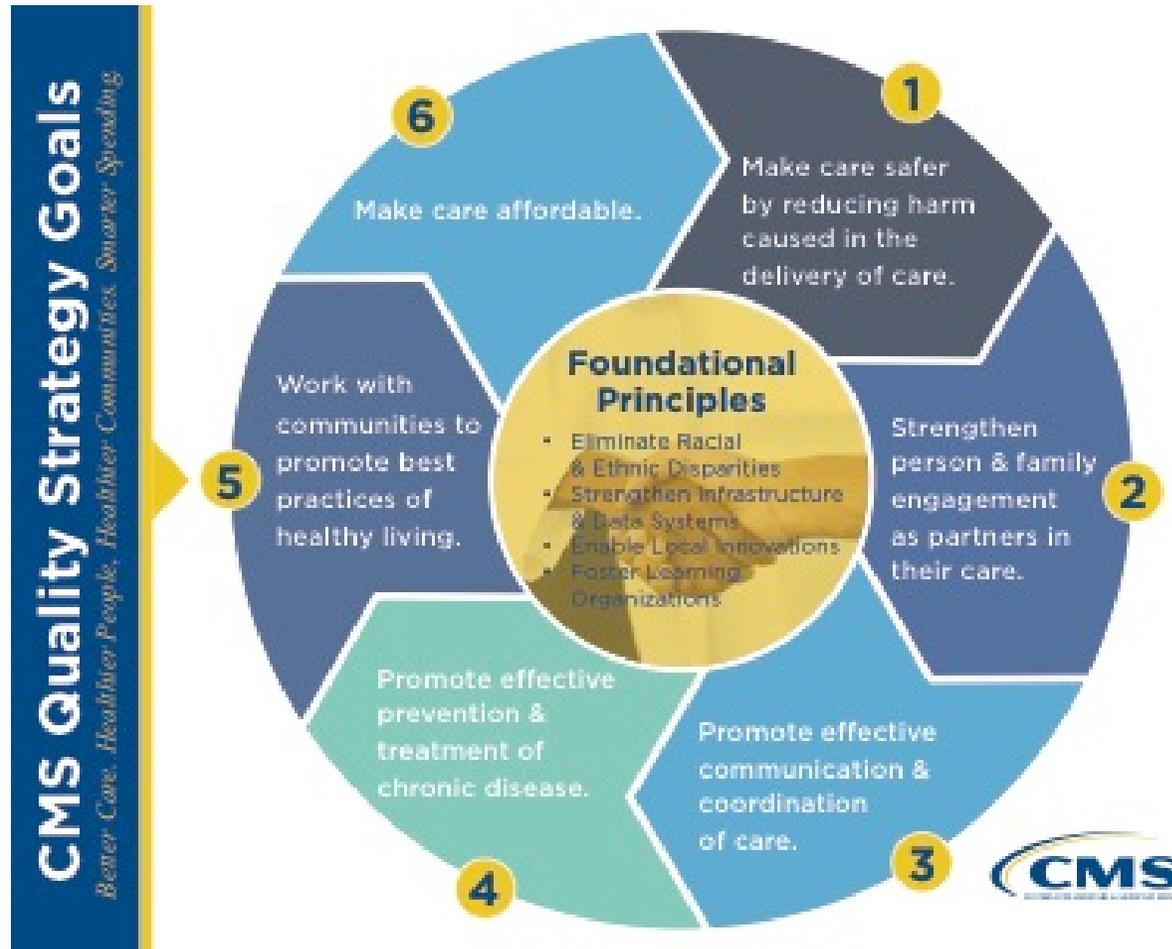
C-suite Leadership

Leaders in adoption of best practices at HENs and hospitals

Federal Government and Agencies

Have the power to influence large audiences and extend reach and frequency of messages

PFE Now Integrated into CMS Quality Strategy



Drivers: Essential to Achieving TCPI Aims

<u>TCPI AIMS/Goals</u>	<u>Primary Drivers</u>	<u>Secondary Drivers</u>
<p>1) <i>Practice Transformation</i>. Evidence of a culture of quality where the vision is clear and data is used to drive continuous improvement in quality, outcomes, cost of care and patient, family and staff experience.</p>	<p>Patient and Family-Centered Care Design</p>	<p>1.1 Patient & family engagement 1.2 Team-based relationships 1.3 Population management 1.4 Practice as a community partner 1.5 Coordinated care delivery 1.6 Organized, evidence based care 1.7 Enhanced Access</p>
<p>2) <i>Effective solutions moving to scale</i>. Evidence of practice spreading effective improvement strategies to full scale for the entire population under its care</p>		<p>Continuous, Data-Driven Quality Improvement</p>
<p>3) <i>High Clinical Effectiveness</i>: Practice is effective in bringing all patient segments to their health status goals.</p>	<p>Sustainable Business Operations</p>	
<p>4) <i>Reduced Avoidable Hospital Use</i>: Rates of readmission and unnecessary admissions for practice's patients have been reduced.</p>		
<p>5) <i>Reduced Unnecessary Testing & Procedures</i>: Practice demonstrates a reduction in unnecessary testing and in the use of the ED by its patient population.</p>		
<p>6) <i>Reduced costs</i>: Practice controls its internal costs as well as other elements of total cost of care.</p>		
<p>7) <i>Documented Value</i>: Practice can articulate its value proposition and increases participation in available value-based payment agreements.</p>		

TCPI Community's Proposed PFE Metrics

Point of Care

- Does the practice use an e-tool (patient portal or other E-Connectivity technology) that is accessible to both patients and clinicians and that shares information such as test results, medication management list, vitals and other information and patient record data?
- Does the practice support shared decision-making by training and ensuring clinicians integrate patient goals and preferences related to culture, language, religion, emotional, and economic status into care plan?

Policy and Procedure

Does practice utilize a tool to assess and measure patient activation?

Is a health literacy patient survey being used by the practice (e.g., CAHPS Health Literacy Item Set)?

Does the practice promote patient-centric medication management practices (self management of medication, etc.)?

Governance

Are there 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.)?

TCPI PFE Metrics Work Group

Diverse Voices



PFE Metrics Work Group

- Regina Holiday, Patient Advocate
- Chris Goodson Patient Advocate
- Richard Scholtz, Patient Advocate
- Howard Robinson, Patient Advocate
- Jack Jordan, Henry Ford (HEN)
- Patricia Merriweather, Telligen (NCC)
- Beverly Johnson, IPFCC
- Mary Minniti, IPFCC
- Sara Guastello, Planetree
- Sam Reynolds, American Medical Association (SAN)
- Amy Gibson, The Patient Centered Primary Care Collaborative (SAN)
- Tara Hacker, The Patient Centered Primary Care Collaborative (SAN)
- Kady Hodges, Iowa Healthcare Collaborative (PTN)
- Cindy Abel, UHC/VHA (PTN)
- Keith Kosel, UHC/VHA (PTN)
- Kathy Williams, UHC/VHA (PTN)
- David Levine, UHC/VHA (PTN)
- Tierra Rollins, Great Lakes (PTN)

PTNs in Action Now on PFE

§ All but three of the 29 PTNs provided updates on progress toward the patient and family engagement goal

Type of PFE Effort	# of PTNs
Practice interventions and technical assistance	13
Patients and families as leaders and advocates	12
Resource curation and development	10
Collaborative learning, work groups, and partnerships	10
Patient and family engagement experts	9
Clinician education and outreach	8
Patient, family, and community education and outreach	4

PTNs in Action Now

PFE Practice Interventions & Technical Assistance

- 13 PTNs
- Implemented patient satisfaction surveys, comment boxes, and other feedback systems
- Encouraged PFE efforts such as the development of advisory boards, care plan sharing, annual wellness visits, and motivational interviewing
- Used baseline practice assessment to discuss PFE and learn about practices' existing PFE efforts
- **PTN Spotlight:** Alabama Physician Alliance PTN

PTNs in Action Now

Patients and Families as Leaders & Advocates

- 12 PTNs
- Reached out to Network partners and SANs to discuss patient, family, and community advocates
- Developed community and/or patient and family advisory boards
- Reached out to patient advocates to be part of leadership team
- **PTN Spotlight:** MidSouth PTN

PTNs in Action Now

PFE Resource Curation and Development

- 10 PTNs
- Identified and promoted relevant tools and resources offered by SANs and other organizations
- Created transformation solutions package that includes resources tailored to PFE
- Integrated Choosing Wisely materials into PTN offerings
- **PTN Spotlight: Quality Impact**

PTNs in Action Now: Other PFE Efforts

- Collaborations with other organizations (10 PTNs)
 - q Share best practices, distribute educational materials, and promote PFE conferences
 - q TCP*i* advisory committee and Affinity Group
- Leveraging of PFE experts (9 PTNs)
 - q National PFE subject-matter experts, TCP*i* faculty and contractors, and QIN-QIO's Patient and Family Council
 - q Lessons learned from patient-centered medical home models and hospitals participating in HEN
- Clinician education and outreach (8 PTNs)
 - q Webinars, collaboratives, and trainings
- Patient, family and community outreach (4 PTNs)
 - q Patient outreach to increase use of MyChart
 - q Community resource cards for each market