Patient and Family Engagement Webinar Series

Patient and Family Engagement: A Critical Ingredient to VBP Success
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### CMS Change Package: Primary and Secondary Drivers

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<th>2.1 Engaged and committed leadership</th>
<th>3.1 Strategic use of practice revenue</th>
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<td>2.2 QI strategy supporting a culture of quality and safety</td>
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<td>1.3 Population management</td>
<td>2.3 Transparent measurement and monitoring</td>
<td>3.3 Capability to analyze and document value</td>
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<td>1.4 Practice as a community partner</td>
<td>2.4 Optimal use of HIT</td>
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<td>1.5 Coordinated care delivery</td>
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<td>1.6 Organized, evidence-based care</td>
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<td>1.7 Enhanced access</td>
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<td>Continuous, Data-Driven Quality Improvement</td>
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<td>Sustainable Business Operations</td>
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“Person and family engagement goes beyond informed consent. It is about proactive communication and partnered decision-making between healthcare providers and patients, families, and caregivers. It is about building a care relationship that is based on trust and inclusion of individual values and beliefs.”

--CMS Person and Family Engagement Strategy
“We’d like to start out being very involved with you but eventually be drawn away to much more interesting cases on Twitter.”
Improving Health, Healthcare Experiences and Outcomes

- Promote Informed Decision Making
- Encourage Engagement & Self Management
- Share Preferences and Values
- Promote PFE Best Practices
- Co-Create Goals
What does this have to do with VBPs?

• Research and outcome evaluation studies in healthcare have repeatedly shown that patient and family engagement improves:
  ✓ Quality of care and patient safety
  ✓ Patient experiences of care
  ✓ Patient treatment outcomes
  ✓ Employee satisfaction
  ✓ Financial performance

• **Patient and Family Engagement Gives You a Competitive Edge.** In a competitive, value-based marketplace, practices will have to compete for business—which makes effective patient and family engagement essential for your continued success.
What does this have to do with VBPs?

• Patient-centered care has been correlated with better health care outcomes and quality of life, as well as other benefits. The use of patient-centered care in a primary care setting has been associated with reduced pain and discomfort, faster recovery in physical health, and improvements in emotional health.
  • “Activated” patients have lower risk of emergency department use and hospitalization, better health outcomes and longer lifespans.
  • Limited health literacy skills are associated with an increase in preventable hospital visits and admissions.

The National Academy of Sciences, 2013
Patient and family engagement is not a new or separate initiative.

It is a critical part of what your practice is already doing to improve quality, satisfy patients and reduce costs.
• 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?

Point of Care

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.)?
Care Transitions Network
PFE Survey Results
Shared Decision-making (N=114)

- 66% train providers in shared decision-making
- 69% ensure that clinical teams engage in and document shared decision-making with all patients
- Two practices reported training staff in collaborative documentation
Medication Management (N=114)

• 92% of practices reported conducting prescription, administration, and review of medications and their side effects

• 78% reported monitoring prescription medications to verify that patients are fulfilling the prescribed medication regimen

• 77% reported ensuring that patients avoid potentially adverse drug interactions
Use of an E-Tool (N=114)

• 10 practices reported using a patient portal within EHR/EMR/electronic health records systems

• Four practices use a practice website with a secure viewing and messaging capabilities

• 70% of practices do NOT use an e-tool that both patients and clinicians can access to share information
  --Six practices said they were working on it!
Patient Activation (N=114)

• Four practices use the Patient Activation Measure (PAM) survey
• One practice uses the Stanford Chronic Disease Self-Efficacy Scale
• 86% of practices responded that they do not use a tool to measure patient activation
  ➢ One practice noted that available tools have not been validated for their specific patient population
  ➢ One practice reported starting to implement the PAM
  ➢ One practice reported implementing and then discontinuing use of the PAM
Health Literacy (N=114)

- Two practices currently use the Short Assessment of Health Literacy (English and/or Spanish versions)
- One practice reported using REALM
- More than 90% of respondents said they do NOT currently use a tool to measure patients’ health literacy
  - One practice noted that available tools have not been validated for their specific patient population
  - One practice reported that they assess health literacy during the clinical interview and assessment
Rapid Estimate of Adult Literacy in Medicine—Short Form (REALM-SF)

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<th>Score</th>
<th>Grade Range</th>
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<td>0</td>
<td>3rd grade and below; will not be able to read most low-literacy materials; will need repeated oral instructions, materials composed primarily of illustrations, or audio or video tapes.</td>
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<tr>
<td>1-3</td>
<td>4th to 6th grade; will need low-literacy materials, may not be able to read prescription labels.</td>
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<tr>
<td>4-6</td>
<td>7th to 8th grade; will struggle with most patient education materials; will not be offended by low-literacy materials.</td>
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<tr>
<td>7</td>
<td>High school; will be able to read most patient education materials.</td>
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TCPI PFE Resources

Upcoming Care Transitions Network PFE Webinars:

• “Moving Past Annual Satisfaction Surveys: Using PFE Data to Drive VBP Transformation” webinar
• “Patient Activation: A Key to Stratifying Patient Risk and Improving Health Outcomes” Data Jam

Archived, On-Demand Resources on the Care Transitions Network Resource Library

• Care Transitions Network webinars on social determinants of health, cultivating a culture of recovery, and other topics
• “Engaging Patients in Informed Decision-Making about Long Acting Injectable Medications” webinar by Northwell Health
• Support and Alignment Network (SAN) Resources, including the Patient-centered Primary Care Collaborative (PCPCC) and the National Nursing Centers Consortium
• Same Day Access webinar with MTM Services
TCPI “Support and Alignment Network” (SAN) Resources

American Medical Association SAN: STEPS Forward Modules
• Forming and Patient and Family Advisory Council
• Listening with Empathy
• Implementing Health Coaching

Person-Centered Primary Care Collaborative SAN
• Training Curriculum: Learning from the Patient Experience
• Tools to Start a Patient and Family Advisory Council
• The Role of Leadership in Creating a Culture of Patient and Family-Centered Care
Questions?
Thank you!

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