PATIENTS AS PARTNERS

IN TRANSFORMATION IN THE RURAL SETTING

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NH Citizens Health Initiative Symposium

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OBJECTIVES

1. Discuss applying principles of practice transformation to the unique characteristics of a rural practice.

2. Learn how patient family advisory councils (PFACs) can be implemented in health care settings.

AGENDA – THE INTERSECTION OF SDOH & PRACTICE TRANSFORMATION IN A RURAL SETTING

I. My personal experience starting a PFAC – lessons learned

II. Why and how to partner with patients

III. Changing Culture – intent, tools and sustainability

TODAY'S AFTER LUNCH/STAY AWAKE PLAN

- ✓ A Question to "run on"
- ✓ Short presentations
- ✓ Engaged audience with time to Share your thoughts on the Question
- ✓ = Leave in Action

WHO IS IN THE ROOM?

the RURAL LENS

#1

QUESTIONS TO RUN ON

How would I start a PFAC?

or

What lessons have I learned from my PFAC?

I STARTED OUT AS A PFAC SKEPTIC!

First Street Family Health (FSFH)

http://www.firststfamilyhealth.com

- Rural 4 doctor, 2 PA physician-owned Family Medicine Clinic in Salida, Colorado.
- We have 8400 empanelled, risk stratified patients.
- Transformation since 2012 with CPCi (Comprehensive Primary Care initiative) – now, thriving in CPC+ track 2
- PFAC started August 2014
- Case study for AHRQ - *Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families*

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/partnering-1.pdf

And me…

- I practiced full spectrum Family Medicine at FSFH from 1993 – 2015 (now retired)
- Physician lead for CPCi 2012 – 2015 –> realized value of PFAC for our practice
- National Faculty for TCPI since December 2015 -> realized value of PFE as a national strategy for transformation

https://edhub.ama-assn.org/steps-forward/module/2702611?resultClick=1&bypassSolrId=J_270

RESOURCES – AMA

STEPS FORWARD MODULE

Forming a Patient Family Advisory Council (PFAC)

https://edhub.ama-assn.org/steps-forward/module/2702594?resultClick=1&bypassSolrId=J_2702594

PFAC: HOW WE GOT STARTED

- National Partnership for Women and Families provided us with the foundation and structure to begin.
- Identified practice members for the council including 1 physician, 1 RN care coordinator, one member from front office, back office and MA staff.
- Recruit patient/family members with focus to fairly represent populations in regards to payer source, age, gender, ethnicity, etc.
- Create ground rules re: confidentiality and meeting protocol, etc.

3 MONTHS LATER, THE FIRST PFAC MEETING

- The PFAC identified issues that were important to patients & the practice and worked together to solve them. The first project will set the tone and build confidence and trust.

- Some topics were generated by the patients and some by the practice

- Now— anytime an issue comes up in the practice, we start by “running it by the PFAC” for input.

FSFH PFAC: HOW IT WORKS

- We met monthly at the beginning to get off to a good start, now we meet quarterly.
- Meeting - 5:30-7 pm in a community space provided by one of the members
- Food! Best chance of participation if you feed us!
- Daycare provisions help

5 YEARS LATER…OUR PFAC IS A VALUABLE PARTNER AT FSFH

- Started by solving a persistent front desk phone reception problem
- Re-vamped new patient forms
- Perform regular clinic walk-throughs
- Re-designed our website
- Currently working on Diabetes QI projects

NEXT…?

What excites me about what I've heard?

Take a few minutes to talk together.
Then, we'll explore our ideas &
plans as a group.

#1

QUESTION TO RUN ON

How would I start a PFAC?

or

What lessons have I learned from my PFAC?

#2

QUESTIONS TO RUN ON

How am I already engaging with patients?

and

What new way to partner with patients would I like to try?

WHY & HOW TO PARTNER WITH PATIENTS (IN A RURAL AREA)

WHY PARTNER W/ PATIENTS AND FAMILIES?

- Bring important perspectives
- Teach how systems really work
- Keep staff grounded in reality
- Provide timely feedback and ideas
- 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”
- **Prioritize precious resources**

MORE REASONS TO PARTNER…

- By definition – the patient perspective on your practice
- Partnership is superior to hiring consultants
- Putting patients first is always the most practical investment providers can make to transform their practices. (Best ROI)
- Accelerates Practice Transformation
- Best way to increase patient or family member's health literacy and engagement
- Prevent burn-out

“Patients and their families are an abundant source of wisdom as we navigate the stormy seas of health care delivery. To go it alone without their partnership is foolish and unwise. With patients as equal partners in the journey of health care transformation, our work together is more fulfilling, more meaningful, and more likely to help them reach their health goals.”

Dr. Joseph Bianco, MD, FAAFP, Director of Primary Care for Essentia Health

Patient-Centered
Primary Care
COLLABORATIVE

PARTNERING TRANSFORMS EVERYTHING

- My transformation from skeptic to spokesperson
- Improved operational performance
- Low cost – high value
- Engaged patients have better outcomes
- Patients take the transformation out of the practice
- This new normal is transforming U.S. healthcare system

A KEY LEVER 4 LEADERS IN PRACTICE TRANSFORMATION

"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."

Reinertsen, J. L., Bisagnano, M., & Pugh, M. D. ***Seven Leadership Leverage Points for Organization-Level***

Improvement in Health Care, **2nd Edition, IHI Innovation Series, 2008. Available at www.ihi.org.**

SO, LET'S CHANGE THE ASSUMPTIONS

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

<u>Understand</u> that families are primary partners in a patient's experience and health.

OPPORTUNITIES TO PARTNER W/ PATIENTS

Opportunity	Examples
1. At the Point of Care	Shared decision-making Safe medication use, “med” management Patient “activation” Patient Portal
2. In the Community	Wellness programs Support groups Community partnerships

MORE OPPORTUNITIES TO PARTNER W/ PATIENTS

Opportunity	Examples
3. At the Organizational Level	PFACs, patient surveys Serving on the Board of Directors Care process mapping Clinical QI teams, oversight, strategy Informing best practices
4. Contributing to Public Policy	Partnering with advocacy groups, public health & government affairs, publishing

THE VALUE OF A PFAC

- Adds a “department” to a practice totally devoted to improving the practice.
- Provides the infrastructure to bring patients into partnership for transformation – assuring patient centered efforts and accelerating transformation.
- PFAC started 8/2014 has generated operational process improvements totaling > $100,000

ONE LAST EXAMPLE…

Partnering with patients to improve health care

Patrick Conway gave an example of a hospital policy that required IV antibiotics for children with osteomyelitis, despite evidence of equal efficacy using orals (and significantly less cost and trauma). He could not change this policy through the usual channels. But, a Shared Decision Aid did the trick as 98% of parents chose oral antibiotics.

What excites me about what I've heard?

Take a few minutes to talk together.
Then, we'll explore our ideas &
plans as a group.

#2

QUESTIONS TO RUN ON

How am I already engaging with patients?

and

What new way to partner with patients would I like to try?

#3

QUESTIONS TO RUN ON

Can you see the intersections?

and

How will you leave in action?

CHANGING THE CULTURE & GETTING PAID FOR IT

THE CULTURE OF PRACTICE TRANSFORMATION

- How do you change the culture of a practice?
- Need the change of culture that Practice transformation provides and patients spur on
- How do you partner with patients?
- SDOH as a partnering mechanism, PFAC as infrastructure
- APMs as the payment mechanism

RESOURCES – PCPCC

PATIENT CENTERED PRIMARY CARE COLLABORATIVE

6 Steps to Creating a Culture of Person and Family Engagement in Health Care – a Toolkit for Practices

https://www.pcpcc.org/sites/default/files/resources/PCPCC-%20Planetree%20PFE%20Culture%20Change%20Toolkit%20050517.pdf

Our 5 year journey through transformation

60+ yo Traditional Medical Practice

Commitment and funds (CPCI)

Improving Performance

Year 1

- Empanelment
- Risk Stratification
- Care Management

Year 2

- Team Based Care
- Learn to Use the Data

Year 3

- Two Areas of Performance
- Patient-Family Advisory Council
- Advanced Practice

Advanced Primary Care Practice

Years 4+

Sustainable business (CPC+)

HOW IT WORKED

INVEST in people and infrastructure with CPCI funds – an additional 13% of budget.

IMPROVED PERFORMANCE through care management, population health, care team redesign.

Partnering w/ Patients strategies are a low tech/low cost way to accelerate the process of transformation.

TIMELINE OF TRANSFORMATION

1950 – 2011

Old Way

Traditional small town doctor's office

FFS

2011 – 2015

Transformation

Comprehensive Primary Care Initiative

FFS + PMPM

2016 Forward

New Way

CPC+ an Advanced APM

FFS (w/ increasing risk) + PMPM + Incentive payments

Exemplar Practice: What FSFH looks like now

- Teams are key – Clinical teams and Practice teams are a new way to care for patients and run a practice
- Payment is complex – Care Management Fee is risk adjusted PMPM payment, Performance Based Incentives linked to pt. exp., CQMs and utilization, and FFS w/ a portion at risk
- Data drives everything - > 85% benchmark on all measures qualify for higher payment levels, access data reviewed in huddles weekly, falls
- Access – multiple care paths allow the practice to remain open to new patients
- Patient Voice – PFAC meets quarterly and is an integral part of the practice

SUSTAINABILITY=PAYMENT REFORM+JOY IN WORK

Payment Reform because it's not possible to transform practice to a patient centered culture on the current "hamster wheel" of FFS.

and

Joy in Work because it's not possible to sustain the work if the workforce if burned out.

WE NEED TOOLS FOR BOTH

PRACTICE TRANSFORMATION IS SUCH A TOOL

- Practice transformation is necessary to succeed in APMs (payment reform)
- Partnering with patients accelerates practice transformation
- Partnering with patients promotes joy in work

PARTNERING WITH PATIENTS IS SUCH A TOOL

- Partnering with patients accelerates practice transformation
- Partnering with patients promotes joy in work
- Partnering with patients both relies on and improves their Health Literacy

Patient & Family Engagement:
Central to QPP Success

Quality Payment Program—

- Quality Measures (60% of MIPS score)
  - Patient experience
  - Medication management
  - Functional status
  - Advanced Care Plan
- Advancing Care Information (25% of MIPS score)
  - Patient portals, Summary of Care, e-Prescribing, patient-specific health education
- Improvement Activities (15% of score)
  - Engage patients and families to guide improvement in the system of care
  - Regularly assess the patient experience through surveys, advisory councils and/or other mechanisms
  - Shared decision making

QPP is a **mechanism** to pay YOU for value.

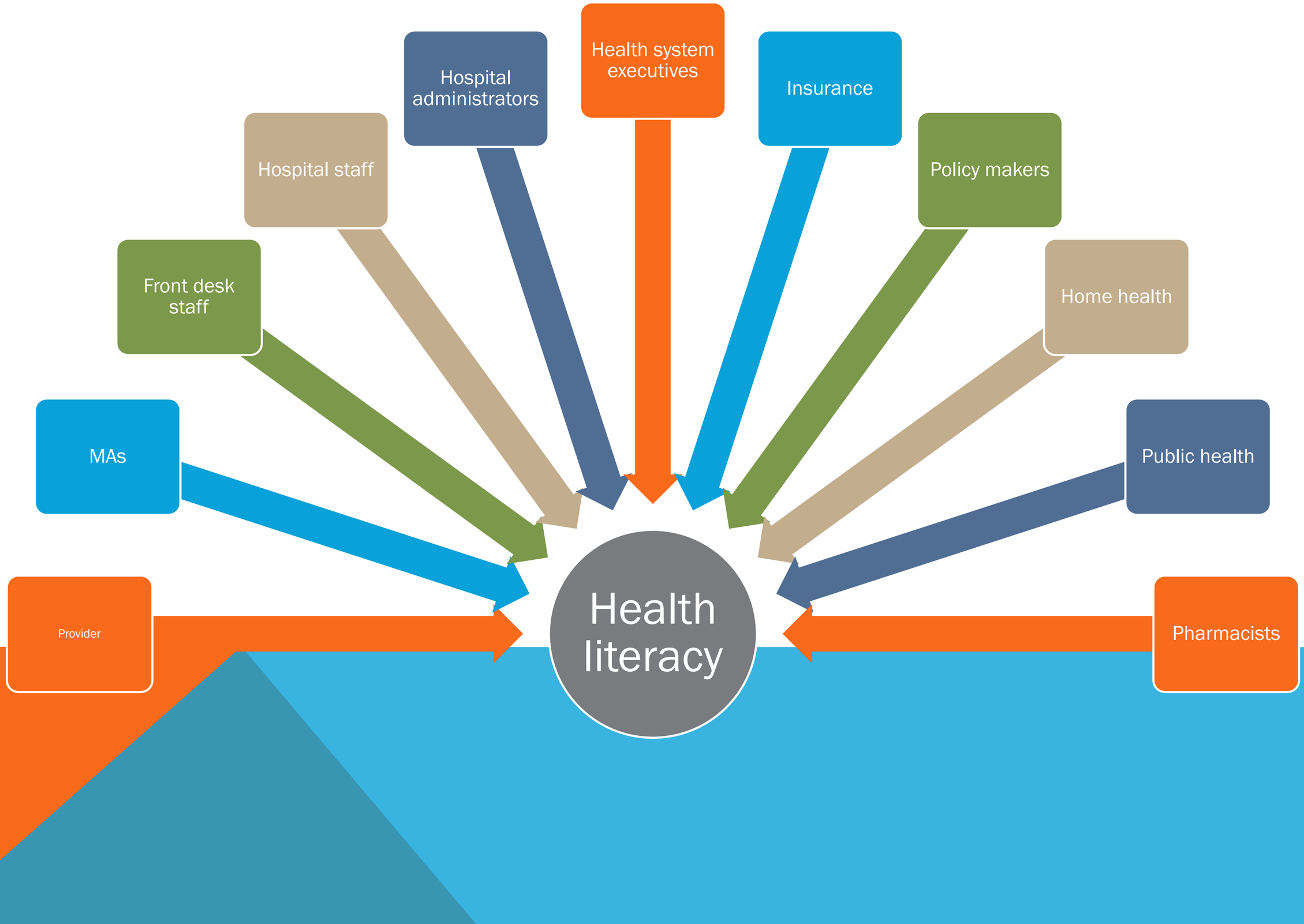
Patient-Centered Primary Care COLLABORATIVE

X4 HEALTH

HEALTH LITERACY IS SUCH A TOOL

- **Health Literacy is critical to Shared Decision-Making – which is the basis of the patient/clinician partnership**
- Partnering with patients both relies on and improves their Health Literacy
- Improvements in Health Literacy provides value to the Patient and the Practice

SDM THROUGHOUT THE HEALTH CARE SYSTEM



THE SDOH IS SUCH A TOOL

Addressing the SDoH is a way to:

- “partner” with the community
- to better care for patients
- that provides a high ROI for the practice

WHAT IS THE RETURN ON INVESTMENT?

- Increased patient engagement and satisfaction
- Reduced ER visits
- Reduced re-admissions
- Better screening and care of chronic diseases
- Decreased medication errors

ALL IMPORTANT METRICS IN APMs

RESOURCES – RWJ FOUNDATION

America's Blind Side

The Overlooked Connection between Social Needs and Good Health

https://www.rwjf.org/en/library/research/2011/12/health-care-s-blind-side.html

FINDINGS…

- 4 in 5 physicians surveyed (85%) say patients' social needs are as important to address as their medical conditions
- 4 in 5 physicians surveyed (80%) are not confident in their capacity to address their patients' social needs
- 3 in 4 physicians surveyed (76%) wish the health care system would pay for costs associated with connecting patients to services that address their social needs

RESOURCES – AMA

STEPS FORWARD MODULE

Addressing the Social Determinants of Health

https://edhub.ama-assn.org/steps-forward/module/2702762

What excites me about what I've heard?

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#3

QUESTIONS TO RUN ON

Can you see the intersections?

and

How will you leave in action?

THANK YOU!

Contact Information

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