



TASK FORCE ON PATIENT AND FAMILY ENGAGEMENT

North Carolina Institute of Medicine
630 Davis Drive, Suite 100
Morrisville, NC 27560
February 18, 2014

Meeting Summary

Attendees

Members: Val Atkinson, Bonnie Britton, Eliane Brown, Janet Bull, Brian Caveney, Peter Chauncey, Betty Currier, Jane Dawson, Lucy Dorsey, Sharon Elliot-Bynum, Calvin Ellison, Nancy Henley, Peter Lichstein, Gladys Lundy, Helen Marie Mack, Jill McArdle, Barbara McNeill, Nidu Menon, John Owen, Belinda Pettiford, Melanie Phelps, Joanne Pierce, Matthew Potter, Parrish Ravelli, Sarelli Rossi, Anita Schambach, Melissa Thomason, Margaret Toman, Doug Urland, RW “Chip” Watkins, Karen Woomer

Steering Committee and NCIOM Staff: Sue Collier, Michael Lancaster, Ruth Petersen, Andrea Phillips, William Schwartz, Kimberly Alexander-Bratcher, Thalia Fuller, Michelle Ries, Pam Silberman, Micha’le Simmons, Adam Zolotor

Guests and Other Interested People: Brent Anthony, Martin Hatlie, Amy Jones, Laura Maynard, Abraham Segres, Swami Reddy, Sarah Potter

WELCOME AND INTRODUCTIONS

Kimly Blanton

Patient Advocate
Co-chair

Robin Cummings, MD

Deputy Secretary
North Carolina Department of Health and Human Services
Co-chair

Warren Newton, MD, MPH

Director, North Carolina AHEC Program
William B. Aycock Professor and Chair
Department of Family Medicine
University of North Carolina School of Medicine
Co-chair

Dr. Newton welcomed everyone, introduced the co-chairs, and asked the participants to introduce themselves.

OVERVIEW OF NCIOM TASK FORCE PROCESS

Adam Zolotor, MD, DrPH

Vice President

North Carolina Institute of Medicine

Dr. Zolotor described the NCIOM, task force process, work of the steering committee, and PFE charge to the participants. He noted that we tried to engage a broader coalition of stakeholders in the process and the frame we use is critical to our work. The level of evidence needed for patient engagement may be other than the randomized control trial. It is important to balance the triple aim as we move forth with our work. The group discussed that this task force was not legislatively directed, but came internally from partners.

PATIENT AND FAMILY ENGAGEMENT: NATIONAL PERSPECTIVES

Martin J Hatlie, JD

CEO, Project Patient Care

President, The Partnership for Patient Safety

Martin J. Hatlie of the *Partnership for Patients* provided the Patient and Family Engagement (PFE) Task Force with foundational frameworks, the goals and metrics of the National Partnership for Patients campaign as they relate to the promotion of patient and family engagement, and examples of the application of PFE strategies in the care process. PFE frameworks adapted patient centered practices into all levels of the socio-ecological model, calling for engagement at the individual, governance/organization and community/policy level. Hatlie shared several definitions of Patient Centered Care (PCC) and the potential impacts on health service delivery including: patient satisfaction, outcomes improvement, patient and family engagement, healthy equity and shared decision-making. At the national level, CMS' Partnership for Patients is tracking newly released PFE metrics in 3,700 hospitals requiring that hospitals 1) discuss discharge planning with patients and families, 2) carry out bedside rounding, 3) have a dedicated staff member or functional area dedicated to PFE 4) have a PFE committee and 5) invite a patient to serve on the governing board. Other applications shared in this presentation also reveal that PFE is becoming a priority even beyond government related initiatives.

PATIENT AND FAMILY ENGAGEMENT: TASK FORCE CONSENSUS-BUILDING DISCUSSION

Sue Collier provided a brief overview of The World Café model of discussion. Then divided the Task Force into four groups. Each of the groups discussed the four levels of patient engagement – direct/individual, practice, hospital/health system, and community. The discussions were centered on what each group member wanted and was willing to give at each level including their ideal experience of care.

The feedback from each of the discussion groups was later aggregated into the following themes:

INDIVIDUAL LEVEL

- Patient-centered health care. Patients should be integrated into the care

team, and should be the center of the health care team. This may require retraining of health professionals who are used to a physician-led team, as well as training for patients to help them become better self-advocates.

- Family involvement. Families should be involved in the care of their loved one, when appropriate. Barriers that prevent family involvement should be addressed and removed.
- Accessible and understandable health information. Health information should be available in multiple forms (eg, written, visual, oral). In addition, health information should be understandable to people with lower health literacy.
- Patient engagement efforts. Patient engagement efforts should be tailored to the needs of specific populations (eg, youth, older adults, people with addiction disorders, people with Limited English Proficiency).
- Community engagement. Involve community members in engaging and educating patients. This may include use of health coaches, lay health workers, peer coaching, or health navigators. The public should be made aware of these community-based health resources (if they exist).
- Best practices. We should assemble information about what works from organizations that have experience with patient engagement. This may include insurers, health systems, or from past research studies.
- Create patient-centered policies. Make it easier for people to do the right thing in taking care of their health.

PRACTICE/PROVIDER LEVEL

- Communication. Health care professionals should treat patients and their families with compassion and respect, and should actively listen to patient concerns. They should be accessible to patients outside of the office. They should have strong communication skills, including strategies to work with people with low health literacy (eg, teach back methods), and understanding how to actively engage patients in their own care (eg, motivational interviewing). Health care professionals should be open to patient and family questions and concerns, and be flexible to consider patient preferences and different treatment approaches.
- Provider competence. Health care professionals should actively communicate and coordinate care with other health care professionals. They should maintain their professional skills and knowledge and be up-to-date on research and treatment options.
- Transparency. Providers should share information about provider or practice level costs and quality.
- Mutual accountability. Patients have a responsibility to educate and advocate for themselves, to ask questions, make sure they understand the providers' treatment recommendations, and explain their treatment preferences.
- Involve patients and their families in practice level advisory committees. Patients and their families should be involved in practice level advisory committees to give input into quality of care, patient flow, and other practices that can impact on the patient care experience.

HOSPITAL AND HEALTH SYSTEM SETTING

- Patient-centered care. Patients should be treated with respect. The health

care system needs to see the patient as a whole person, not just a series of health problems. Patients should be acknowledged and actively recruited to be part of the care team.

- Family involvement: Families should be involved as part of the care team (when appropriate). Health system policies which create barriers to family involvement (eg, hospital visitation policies) should be removed.
- Communication with patients and families. Health care providers should communicate with patients through the whole process. There should be a free flow of information, including patient access to electronic health records, clinical summaries that are given to patients, shared bedside check-ins (that actively include the patient and his/her family), and transparency on quality and pricing.
- Communication across providers. While patients want to be kept informed, they should not have to serve as the point of contact between all the health care professionals who treat them. The system should be designed to ensure that providers coordinate and share information among themselves, and/or that there is a care coordinator who can facilitate the sharing of information between health care professionals and can help translate health care information to the patient.
- Provider training. Providers need to be trained to be better communicators with patients. They should be trained on health literacy, cultural competency, motivational interviewing, and other effective communication strategies.
- Involve patients and families in health system boards and committees. Patients and their families can provide meaningful input into hospital and health system committees focused on patient safety and quality improvement. There should also be easy mechanisms to give feedback to the health care institution (whether positive or negative).

COMMUNITY LEVEL

- Patient-centered through continuum of care. The health system needs to be refocused to be patient-centered through the whole continuum of care, from wellness/prevention to long-term and end-of-life care.
- Communication. Health care providers and systems should use a range of different mediums to meet patients and their families “where they are.” This includes face-to-face communication, as well as use of social media or mobile/internet messaging.
- Coordination of all systems. There should be greater coordination of all the different organizations and agencies that influence health, including lay health advisors and peer programs, school-based health services, faith based organizations, and traditional health care partners.
- Involve community partners. The health care needs of patients and their families cannot be addressed entirely through the health care system. Health is influenced heavily by community, environment, and socioecological factors. Therefore, the health care system should actively reach out to and involve community partners. Health care professionals should be educated about existing community resources.
- Health in all policies. Communities should incorporate health into all policies to support wellness. Communities should include places to exercise, buy healthy foods, etc.

- Individuals and families should be engaged in all levels of health policy making. Patients should be educated and empowered about how to influence broader health policies.

NEXT STEPS & FEEDBACK

The group reconvened so that the facilitators could provide brief overviews of their discussions. The group was reminded of the next meeting date of March 20th and its focus on a framework to help move the work forward.