

**Maine PCMH Pilot & First STEPS Learning Initiative**  
**"Engaging patients and families – to improve access and care coordination"**



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CMHI (Center for Medical Home Improvement) [www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org)





"Animal, Vegetable, Miracle", Barbara Kingsolver  
 Some Medical Home Parallels

Local Tomato Grower	Medical Home?
Part of the local community	
"Barter" or exchange assets	
Value health, quality products, and safety	
Sell "product" directly to customers	
Livelihood is <i>mission</i> as well as business	
Customers show up week after week, at a community gathering place	
First names common; open door/welcoming policy	
Name of the <i>heirloom</i> tomato she is growing? { ? }	

Local Tomato Grower	Medical Home?
Part of the local community	✓
"Barter" or exchange assets	✓
Value health, quality product, and safety	✓
Sell "product" directly to customers	✓
Livelihood is <i>mission</i> as well as business	✓
Customers show up week after week, at a community gathering place	✓
First names common; open door/welcoming policy	✓
Name of the heirloom tomato? She is growing { "TRUST" }	

Local Tomato Grower	Medical Home?
Part of the local community	<b>Implicit in PCMH</b>
"Barter" or exchange assets	<b>Learn patient assets</b>
Value health, quality product, and safety	<b>Establish shared goals</b>
Sell "product" directly to customers	<b>Like product &amp;_</b>
Livelihood is <i>mission</i> as well as business	<b>Better/ care &amp; better health</b>
Customers show up week after week, at a community gathering place	<b>Coordination</b>
First names common; open door/welcoming policy	<b>Access</b>
{Speed of <i>TRUST</i> by (7 Habit's Stephen Covey )	


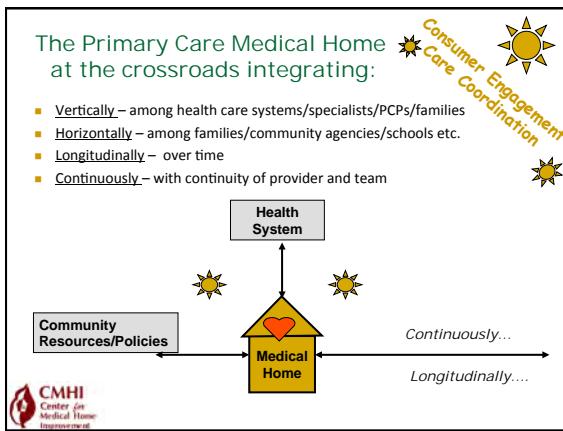
**The Medical Home - the quality standard of excellence for 21<sup>st</sup> Century primary care**

- CMHI defines the medical home as...
  - a community-based, primary care setting which provides and coordinates high quality, planned & patient / family-centered:
  - health promotion
  - acute illness care &
  - chronic condition management




**Goals Today: (Leave you with practical strategies/tips)**

1. Describe the relationship between engaging patients/families in care and access/care coordination
2. Illustrate patient/family stories as valuable teaching and learning strategy
3. Distinguish between/among:
  - Engaging patients in their care
  - Involving them in practice improvement/redesign
  - Partnering as advocates for the greater good of the community
4. Using learned tips list and plan to test **at least 2** methods to engage and learn from patients and families "by the end of February" (PDSA)





**Parent Partner**





**CMHI's Medical Home TAPPP™ (Gap) Analysis: Transformation Methods Infused with Patient and Family Engagement**

- **T**eamwork
- **A**ccess & Communication
- **P**opulation Approach
- **P**lanned, Coordinated Care
- **P**atient & Family-Centered Care



### Teamwork & patient family engagement


- **Goal of teamwork:**  
Informed, prepared, proactive and highly functioning teams partnering with fully informed, activated, and supported patients and families.
  - (NPWF- 9 principles, all state "the care team" with the patient at the center... coordination, access, management, etc. [www.nationalpartnership.org/](http://www.nationalpartnership.org/))
  - Relational coordination/teamwork (Gittel)
    - Shared goals
    - Timely frequent communication
    - Mutual Respect
  - Example: Amy B.
    - Goals of the patient and family



### Access & patient family engagement



**Goal:** Enhance practice access (parameters) and the communications about access availability among patients, families and medical home staff while increasing quality and decreasing costs.

- Appointments & beyond (what works at your practice?):
  - **People** - designated staff/care coordinator/on phone; who to call/how when
  - **Physical access** – doors, scales, exam tables, rooms for family, right away if needed (e.g. complexity leads to triaged rooming)
  - **Information** – MEMORY of needs/requests, MyChart/portals, primary doc away, care plan for back up for what/when doc away; roomed stat;
  - **Activated patient access** - (Story of blood draw and standing orders) (family idea)
  - **Access Partnerships** - to stay out of emergency room, goal: who to call, what to do, when if (care plans)



### Population & patient family engagement

- Population (family centered population approaches)
- Goal: Proactively provide the right care at the right time for defined patient populations.
- Quick Example
  - Mrs. D. - language/complexity

### Planned Coordinated Care

Goal Coordinated, comprehensive, continuous care with a patient and family-centered longitudinal perspective.

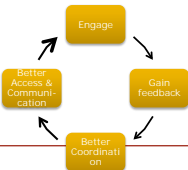

- Consumer - but I am the coordinator
- Practice has my back?
- Example: Coordinator/pharmacists -
  - Story of couple and meds –
    - Care coordinator, engagement and trust
    - Reconciliation/pharmacy
    - CC follow-up up; couple sharing prescription to save




### Patient & Family Centered Care


**Goal:** Partnerships form the foundation for effective and efficient, goal oriented care.

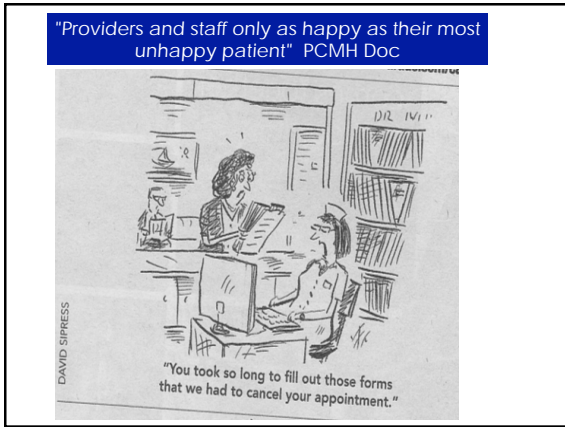
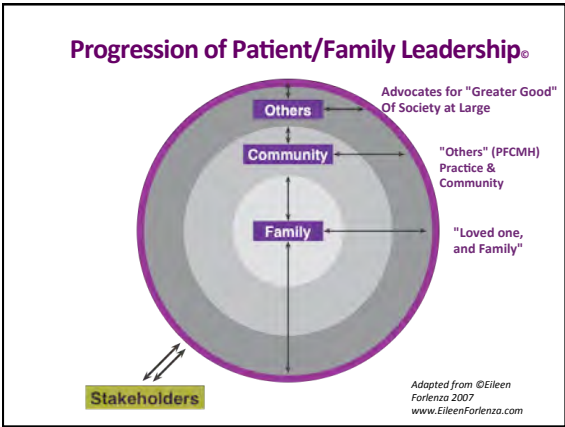
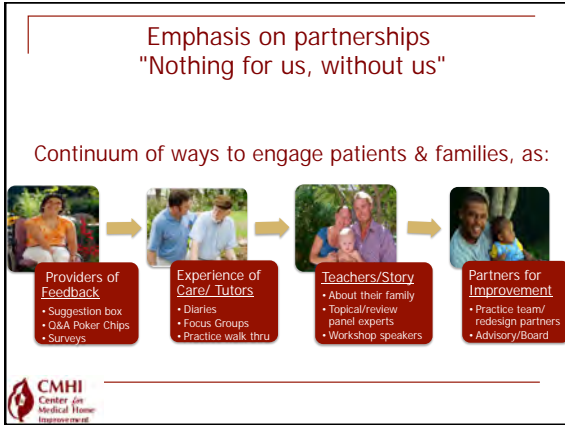
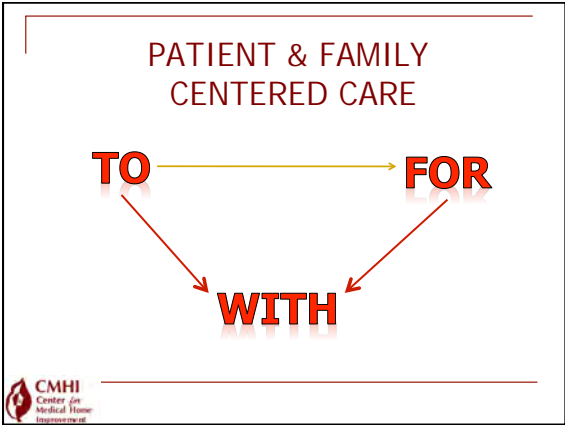
- "What about the difficult/hard patient or family"
  - Law- hard cases make bad law
  - Medicine- exceptional cases make bad rules or rare occasions make for bad rules for usual occasions

### Mrs. Barb Farrell

- Story
- Q & A



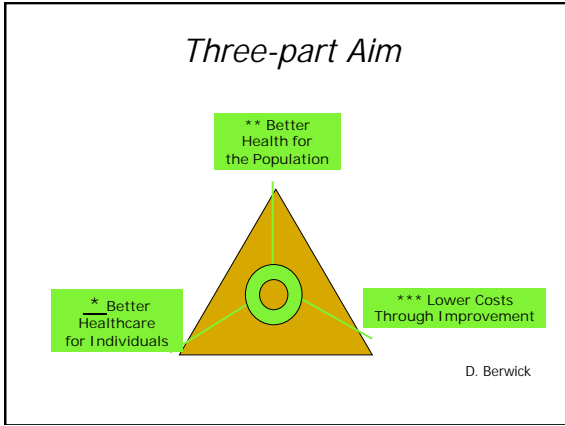


### Practical Strategies/Tips

Want to	Ask yourself/team	Ideas:
Engage consumer partners	Goal, topic, target age, range of health needs and experiences	Think several, variety of voices
Recruit	Think of patients/families – who are you learning from	Use messaging (web, etc.); referrals all staff
Engage staff	Are there objections, worries, ideas	Gain input, ideas Staff skill building?
Extend the experience	Successful meetings: best time for all, stipends, food, shared agenda, laughter	Identify mentor for partners & staff contact for them
Succeed	Clear shared goals, timeline, communication, mutual respect and process reflection	Set enough time at first meeting; gain rapport & habits (ground rules)

Share with all patients & families the input of your patient/family advisors and how you have used this data to improve care!


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Center for Medical Home Improvement



## Principles to remember


Three Maxims -	Meaning
(1) "The needs of the patient (family) come first."	The idea that designs of (practice)habit or convenience are subordinate to designs that serve the patient
(2) "Nothing about me without me." (Nothing for us without us)	Levels of transparency and participation uncharacteristic of most health care systems.
(3) "Every patient is the only patient."	We are "guest" in the patient's life; expresses confidence in the feasibility and desirability of customization of care to the level of the individual (memory).

D. Berwick




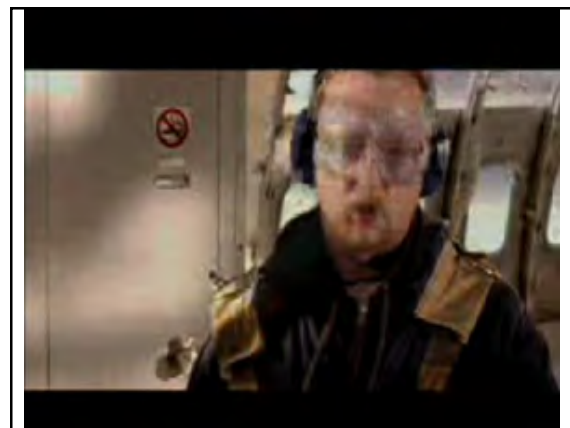
### Fact or Fiction?

- Engaging patients and families is related to better access and care coordination?
- There is only one *right* way to engage consumers of health care?
- We should design health care processes based upon our experiences with our most difficult patients?
- The triple aim is inconsistent with engaging patients and families?
- With consumers as a part of the team all staff are better equipped to support patients and families?



### Fact or Fiction?


- Engaging patients and families is related to better access and care coordination? FACT
- There is only one *right* way to engage consumers of health care? FICTION
- We should design health care processes based upon our experiences with our most difficult patients? FICTION
- The triple aim is inconsistent with engaging patients and families? FICTION
- With consumers as a part of the team - all staff are better equipped to support patients and families? FACT

## Patient & Family-Centered Medical Home

*Across the lifespan for children, youth, adults and their families*

- Lifespan -



Adult Care



Pediatric Care

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