NATIONAL ASSOCIATION OF
Community Health Centers®

Patient Engagement

07.13.21

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Quality Center (Host)

Layout

Quality Center

Host

Participants

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Panelist: 1

QC Quality Center
Host

Attendee:

CS Camila Silva (NACHC)
Me

Raise your hand button

Unmute Share ··· Participants Chat

Chat: When using the chat, please send the message to “Everyone”

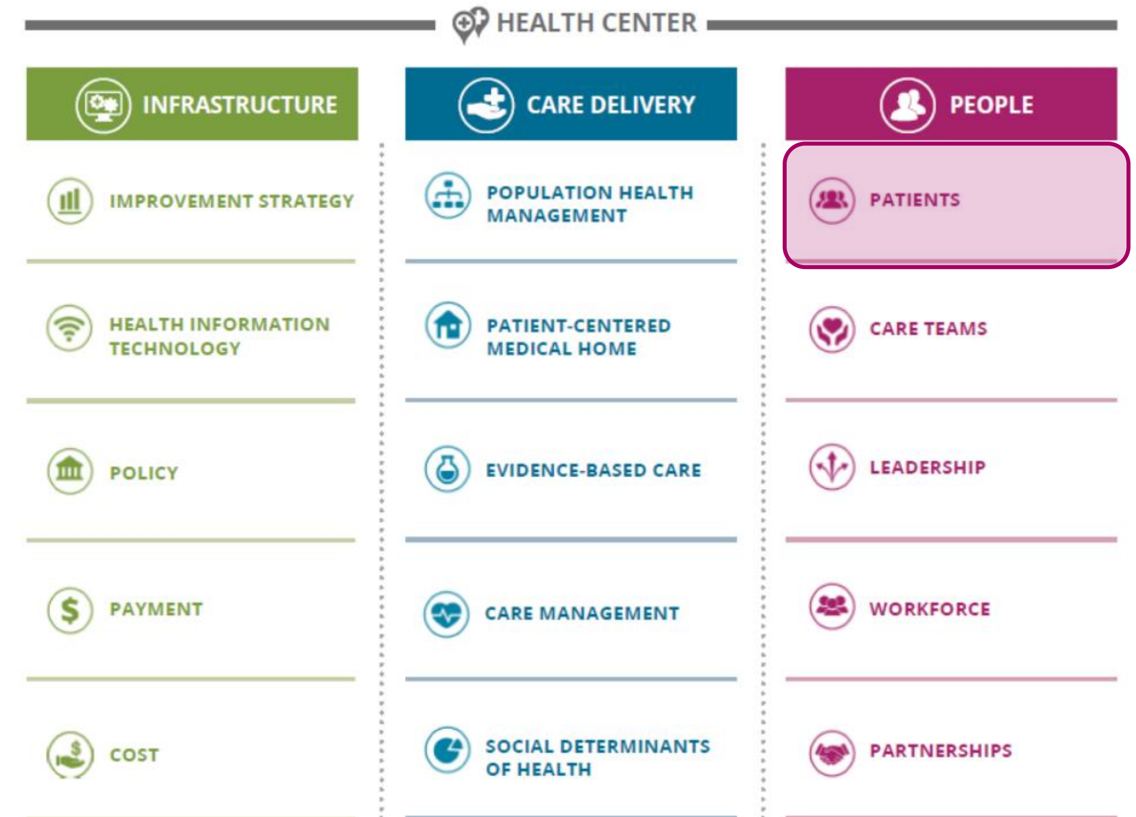
THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF
Community Health Centers®

Value Transformation Framework



https://www.nachc.org/clinical-matters/value-transformation-framework/

PATIENTS

Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Pt-Engagement-AG_November-2019.pdf

mpca THE VOICE OF COMMUNITY HEALTH CENTERS

Candy Vertalka, RN
Director Value Transformation

Cheryl Gildner
Data Manager

Overview

1. MPCA Structure
2. Strategic Vision
3. Value Transformation Team
4. Access to Care Collaborative
5. Tools and Technology Support
6. Measuring Transformation Using Data

Value Transformation Team – Improving Patient Engagement and Access to Care

Current Collaboration Structure

Michigan Quality Improvement Network
Data Driven Quality

PCA (1978)

HCCN (2012)

CIN (2015)

MCHN MICHIGAN

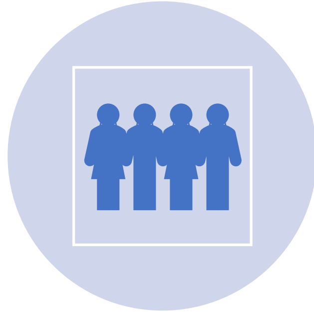
45 CHCs

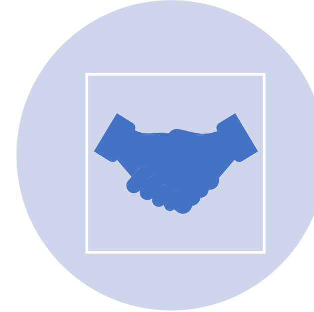
40 CHCs

32 CHCs

Health Centers

Collaboration Outcome





SHARED LEADERSHIP

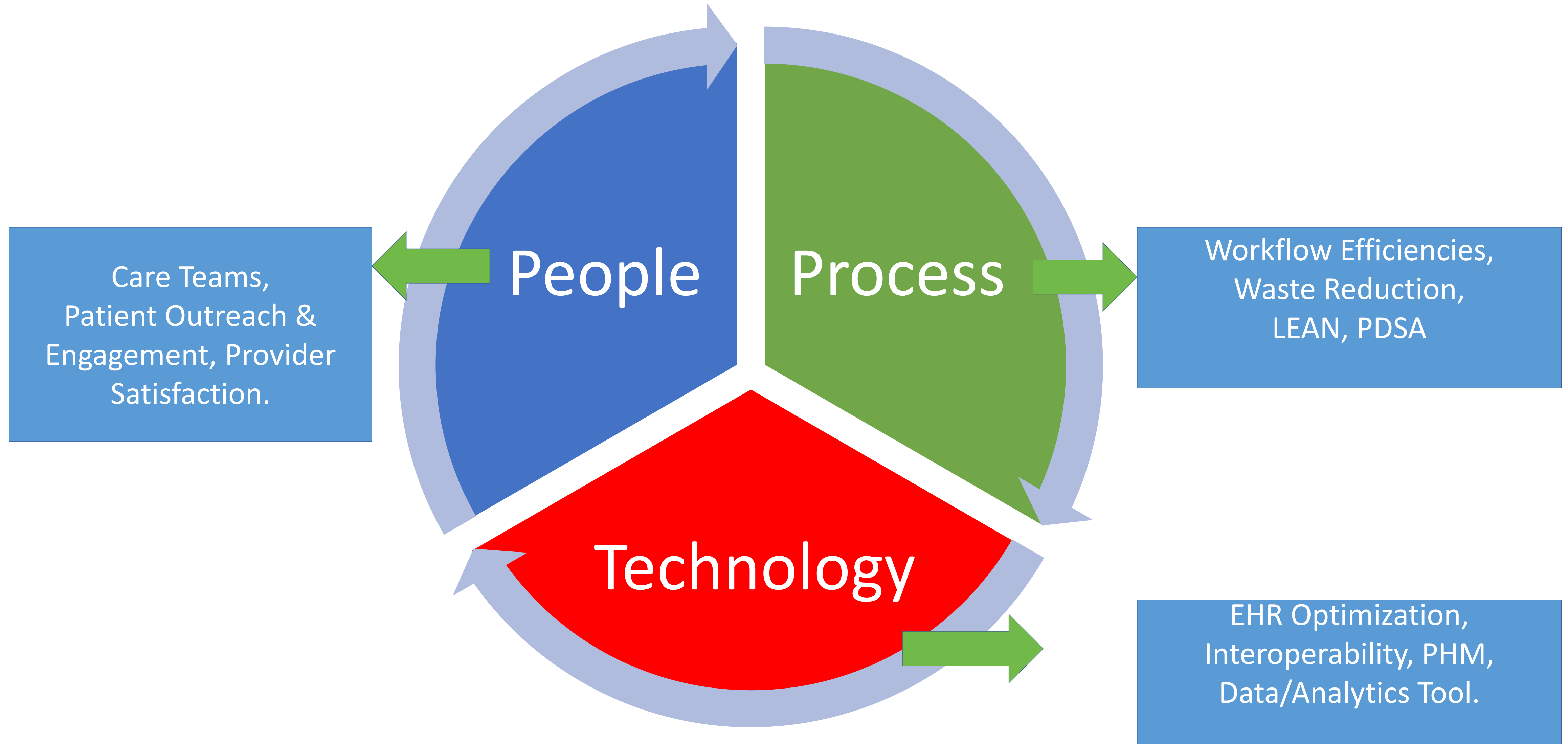
SHARED STAFFING

SHARED STRATEGIC VISION

MPCA Strategic Goals

1. Delivery System Transformation
2. Importance of Data & Analytics
3. Payment Reform

Potential Transformation Solutions



Value Transformation Team

Inception, formation, creation and implementation

- PCA, HCCN and CIN Vision
- Three members of Core VT Team, Data Team, Population Health and Technology
- Expertise in Performance & Quality Improvement
- Knowledge and Experience in Lean Methodology and Thinking

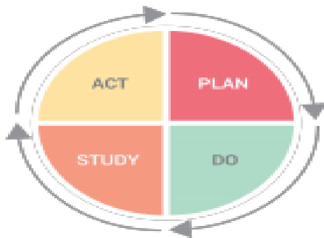
Access to Care Collaborative

- ***IHI Collaborative Framework***

- Seven Participating Health Centers
- Four Deep-Dive Learning Sessions
- Internal Expertise
- Tools for Improving Access to Care
    - Luma Health
    - Azara

Deep Dive Learning Sessions

- *Session One – Tools for Optimizing Messaging*
- *Session Two – Patient's unseen in 12+ months*
- *Session Three – Patients with open care gaps/unmet needs*
- *Session Four - Patients assigned but never seen*
- *Wrap-Up - Health Center Report-Out*



PDSA Worksheet

Team Name:	Date of the test:	Test Completion Date:
Overall team/project aim:		
What is the objective of the test:		

Plan

Briefly describe the test:

How will you know that the change is an improvement?

What driver does the change impact?

What you predict will happen?

List the tasks necessary to complete this test (What)	Person responsible (Who)	When	Where
1.			
2.			
3.			
4.			
5.			
6.			

Plan for collection of data:

Do

Test the changes.

Was the cycle carried out as planned? Yes....... No......

Record data and observations.

What did you observe that was not part of our plan?

Studv

Did the results match your predictions? Yes....... No......

Compare the result of your test to your previous performance:

What did you learn?

Act

Decide to adopt, adapt, or abandon.

☐ Adapt: Improve the change and continue testing plan. Plans/ changes for next test

☐ Adopt: Select changes to implement on a large scale and develop an implementation plan and plan for sustainability

☐ Abandon: Discard this change idea and try a different one

Tools for Outreach and Engagement

Optimizing and standardizing Outreach and Engagement

- **Luma Health**
  - On June 30, 2020, MPCA launched a partnership with Luma Health Patient Outreach and Engagement Tool
  - Currently there are 23 Health Centers enrolled and are in various stages of use. One additional Health Centers with pending enrollment.
  - HCCN provided financial support for the Implementation fee and first year's cost of Luma
  - Integration to Azara is live.
- **Other tools being used to name a few**
  - Clearwave
  - Relatient
  - eClinicalWorks Healow

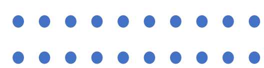
Deep Dive into Outreach & Engagement

Value Transformation team members and other internal experts were available to provide training, education and support for health center staff using Luma or any other platform to:

- Customize, select and send broadcasts via text, voice, or email
- Troubleshoot issues related to messaging
- Strategize outreach and engagement messaging approaches
- Review language/forms for obtaining consent
- Review messaging promotion strategies and opt-out process
- Workflows, staffing, and other operational assistance

Resources: Tools for any platform

- Messaging templates for all messaging categories available in English, Spanish, and Arabic:
  - New Patient Welcome; Newly Assigned, Never Seen; Existing Assigned Patient Not Seen in 12 Months; Gap in Care; Health Risk Assessment; High Utilizer, Follow-up Post Hospital Admission or ED Visit
- Patient Engagement Guidelines
- Messaging & Outreach Calendar



Messaging Library: English, Spanish, and Arabic

Message Description	Example Message 1
MPCA Introductory Patient Engagement Message	{{facility.name}} will send healthcare information by text and voice message. For questions you can always reach us at {{facility.phone}}. Reply STOP to unsubscribe
MPCA Basic Access to Care Patient Overdue for Follow-Up Message	At {{facility.name}} we recommend regular visits to manage some conditions. Could you be overdue for an appointment? Call us at {{facility.phone}} to schedule.
MPCA Basic Access to Care Patient Not Seen in 12 Months Message	Has it been over a year since you've seen a doctor? Call {{facility.name}} at {{facility.phone}} now to stay current on vaccines and exams
MPCA Basic Gap in Care Cervical Cancer Screening	Call {{facility.name}}{{facility.phone}} to schedule a Health Screening appointment now. We look forward to seeing you!
MPCA Basic Gap in Care Message HbA1C Testing	The A1c test shows your blood sugar levels (glucose) for the last 3 months. Schedule an A1c exam today by calling {{facility.name}} at {{facility.phone}}

ENGLISH

Message Description	Example Message 1
MPCA Introductory Patient Engagement Message	{{facility.name}} enviará información de atención médica a través de mensajes de texto y mensajes de voz. Si tiene preguntas, siempre puede comunicarse con nosotros al {{facility.phone}}. Conteste ALTO *(STOP)* para cancelar su suscripción.
MPCA Basic Access to Care Patient Overdue for Follow-Up Message	En {{facility.name}} recomendamos realizar visitas regulares para controlar algunas afecciones. ¿Es posible que ya esté retrasado y sea tiempo de concertar una cita? Llámenos al {{facility.phone}} para programarla.
MPCA Basic Access to Care Patient Not Seen in 12 Months Message	¿Ha pasado más de un año desde que consultó a un médico? Llame a {{facility.name}} al {{facility.phone}} hoy mismo para mantenerse al día con sus vacunas y exámenes.
MPCA Basic Gap in Care Cervical Cancer Screening	Llame a {{facility.name}} al {{facility.phone}} para programar ya una cita para una prueba de detección para la salud. ¡Esperamos verle pronto!
MPCA Basic Gap in Care Message HbA1C Testing	La prueba A1c muestra los niveles de azúcar en sangre (glucosa) de los últimos 3 meses. Programe un examen A1c hoy mismo llamando a {{facility.name}} al {{facility.phone}}.

SPANISH

Patient Engagement Guidelines

- The purpose of the patient engagement guidelines was to provide a consistent framework for Michigan health centers to communicate with and outreach to patients
- The guidelines proposed an organized, systematic approach to patient communication and outreach embedded in a health center's quality plan, with communication outcomes oriented toward access to care, gaps in care, and social and health risk assessment + intervention
- The guidelines were used to structure electronic and personal outreach

2021 Patient Engagement Guidelines
Quick Reference Messaging and Outreach Calendar

Week 1:
Access to care/not seen in 12 mos: **electronic msg 1**
Newly assigned patient: **letter/outreach**
Qtr 1 Health Risk Assessment: **electronic message**

			March	April	May	June	July
			Access to Care/Not Seen in 12 months lectronic essage 1 wly Assigned tient tter/Outreach ccess to are/Patient Never Seen Outreach	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Q2 Health Risk Assessment Electronic Message	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Access to Care/Patient Never Seen Outreach	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Access to Care/Patient Never Seen Outreach	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Q3 Health Risk Assessment Electronic Message
	Health Risk Assessment Outreach	n/Not 12 onths Outreach Health Risk Assessment Outreach	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach Health Risk Assessment Outreach	Q1 Access to Care/Patient Never Seen Letter/Outreach Health Risk Assessment Outreach	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach	Q1 Access to Care/Patient Never Seen Letter/Outreach
Week 3	Newly Assigned Patient Outreach Gap in Care Electronic Message (Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Gap in Care Electronic Message Optional) Gap in Care Letter
Week 4	Q1 Access to Care/Patient Not Seen in 12 Months Electronic Message Q1 Access to Care/Patient Not Seen in 12 Months Letter	Patient Never Seen Outreach High Utilizer Outreach	Patient Never Seen Outreach High Utilizer Outreach	Q2 Access to Care/Patient Not Seen in 12 Months Electronic Message Q2 Access to Care/Patient Not Seen in 12 Months Letter	Patient Never Seen Outreach High Utilizer Outreach	Patient Never Seen Outreach High Utilizer Outreach	Q3 Access to Care/Patient Not Seen in 12 Months Electronic Message Q3 Access to Care/Patient Not Seen in 12 Months Letter

	August	September	October	November	December
	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Access to Care/Patient Never Seen Outreach	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Access to Care/Patient Never Seen Outreach	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Q4 Health Risk Assessment Electronic Message	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Access to Care/Patient Never Seen Outreach	Access to Care/Not Seen in 12 months Electronic Message 1 Newly Assigned Patient Letter/Outreach Access to Care/Patient Never Seen Outreach
	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach Gap in Care Targeted List Outreach	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach Gap in Care Targeted List Outreach	Q1 Access to Care/Patient Never Seen Letter/Outreach Gap in Care Targeted List Outreach	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach Gap in Care Targeted List Outreach	Access to Care/Patient Never Seen/Not Seen in 12 months Outreach
Week 3	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter	Newly Assigned Patient Outreach Patient Never Seen Outreach Gap in Care Electronic Message Optional) Gap in Care Letter
Week 4	Patient Never Seen Outreach High Utilizer Outreach	Patient Never Seen Outreach High Utilizer Outreach	Q4 Access to Care/Patient Not Seen in 12 Months Electronic Message Q4 Access to Care/Patient Not Seen in 12 Months Letter	Patient Never Seen Outreach High Utilizer Outreach	Patient Never Seen Outreach High Utilizer Outreach

Health Center Message

- Use of the patient engagement guidelines is intended to be a team effort, building upon existing team member contributions in these areas and adding capacity for some of the most time-intensive work
- The engagement effort is also intended to be a sustained component of your overall quality strategy rather than a temporary program or project
- The end of the collaborative was not an end to the work on outreach and engagement but a “call to action”

Individual Health Center Support/Assistance

- Support for PCMH Implementation and Maintenance
- Assistance with Identifying Priority Improvement Areas and Development of Action Plans Focusing on Access to Care, Clinical Quality, Operational Excellence or Financial Strength
- On-site Support – Rapid Improvement Events (Kaizen)
- Development and Use of Value Transformation Dashboard in Azara
- Provide Link to Additional Expertise within the PCA

Using Data to Support Value Transformation

Goals:

Match Member Rate Per Plan

Primary goal 95%

Secondary goal 87%

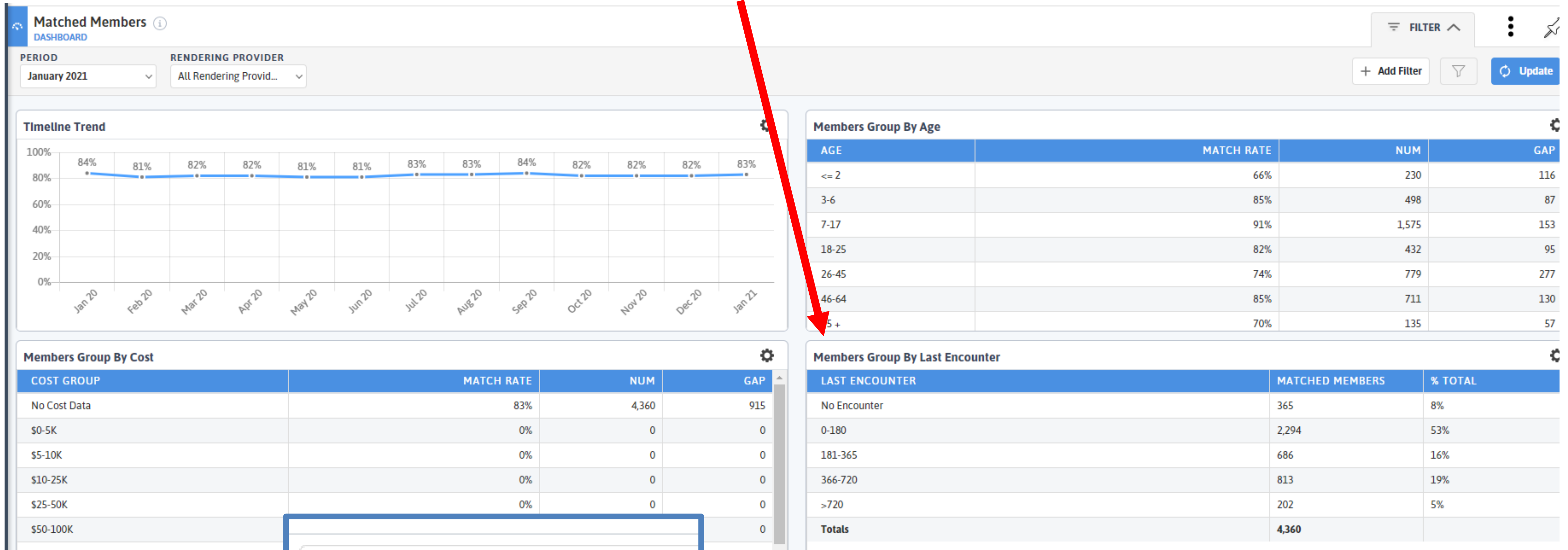
Access -Visit in the year

Primary goal 91%

Secondary goal 85%

Clinical Quality – Meet 4+ measures at the 75th percentile

Matched Member Dashboard



Members Group By Age

AGE	MATCH RATE	NUM	GAP
<= 2	66%	230	116
3-6	85%	498	87
7-17	91%	1,575	153
18-25	82%	432	95
26-45	74%	779	277
46-64	85%	711	130
5 +	70%	135	57

Members Group By Cost

COST GROUP	MATCH RATE	NUM	GAP
No Cost Data	83%	4,360	915
$0-5K	0%	0	0
$5-10K	0%	0	0
$10-25K	0%	0	0
$25-50K	0%	0	0
$50-100K			0

Members Group By Last Encounter

LAST ENCOUNTER	MATCHED MEMBERS	% TOTAL
No Encounter	365	8%
0-180	2,294	53%
181-365	686	16%
366-720	813	19%
>720	202	5%
Totals	4,360	

Comparison GROUP BY Last Encounter

LAST ENCOUNTER	RESULT
366-720	
>720	
181-365	
0-180	

Or use Matched Member Measure and group by last encounter

Patient Outreach

FILTER

+ Add Filter

Export Excel

Export to LUMA

Create Cohort

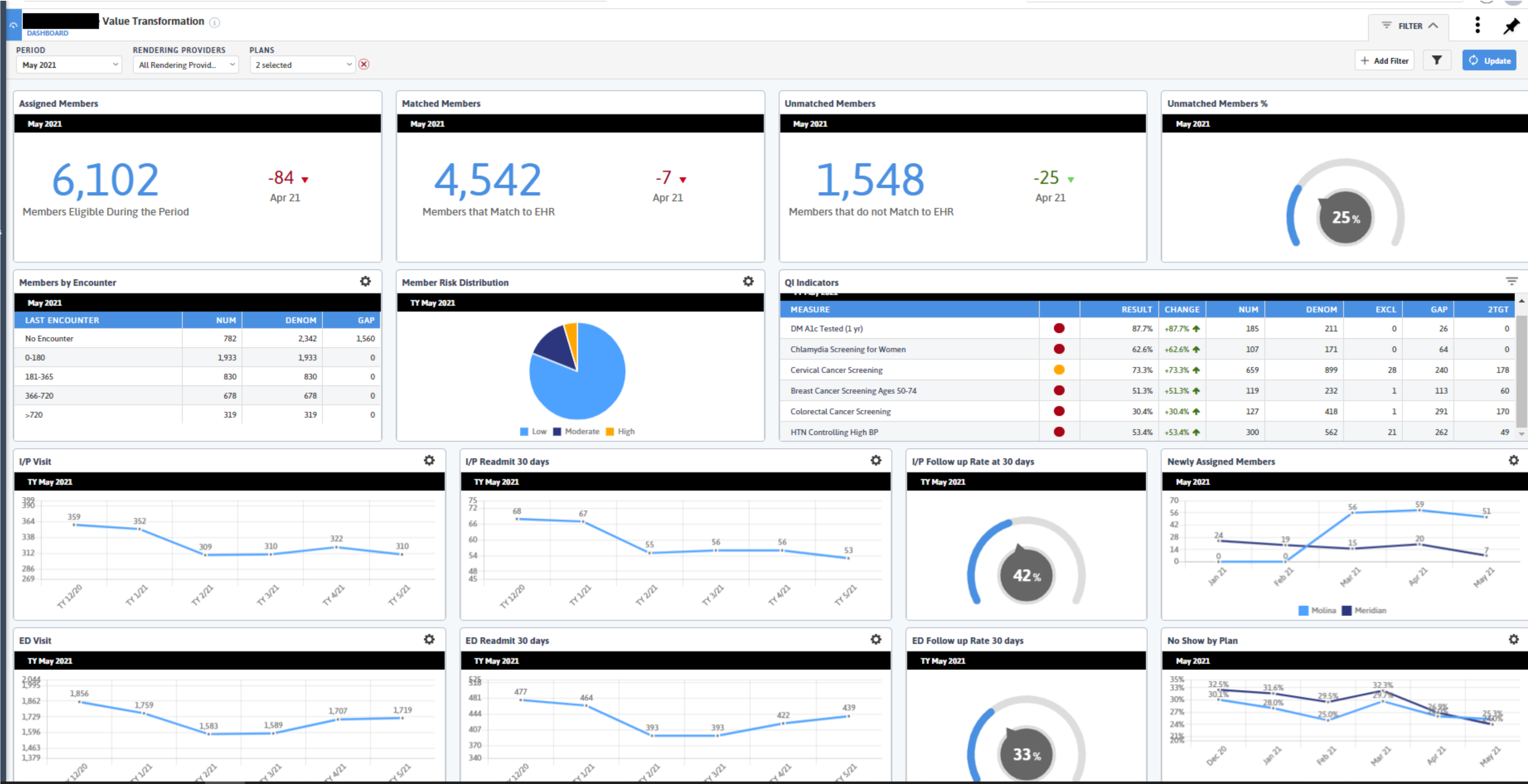
DETAIL LIST | VALUE SETS

All | Gaps | Num | Excl

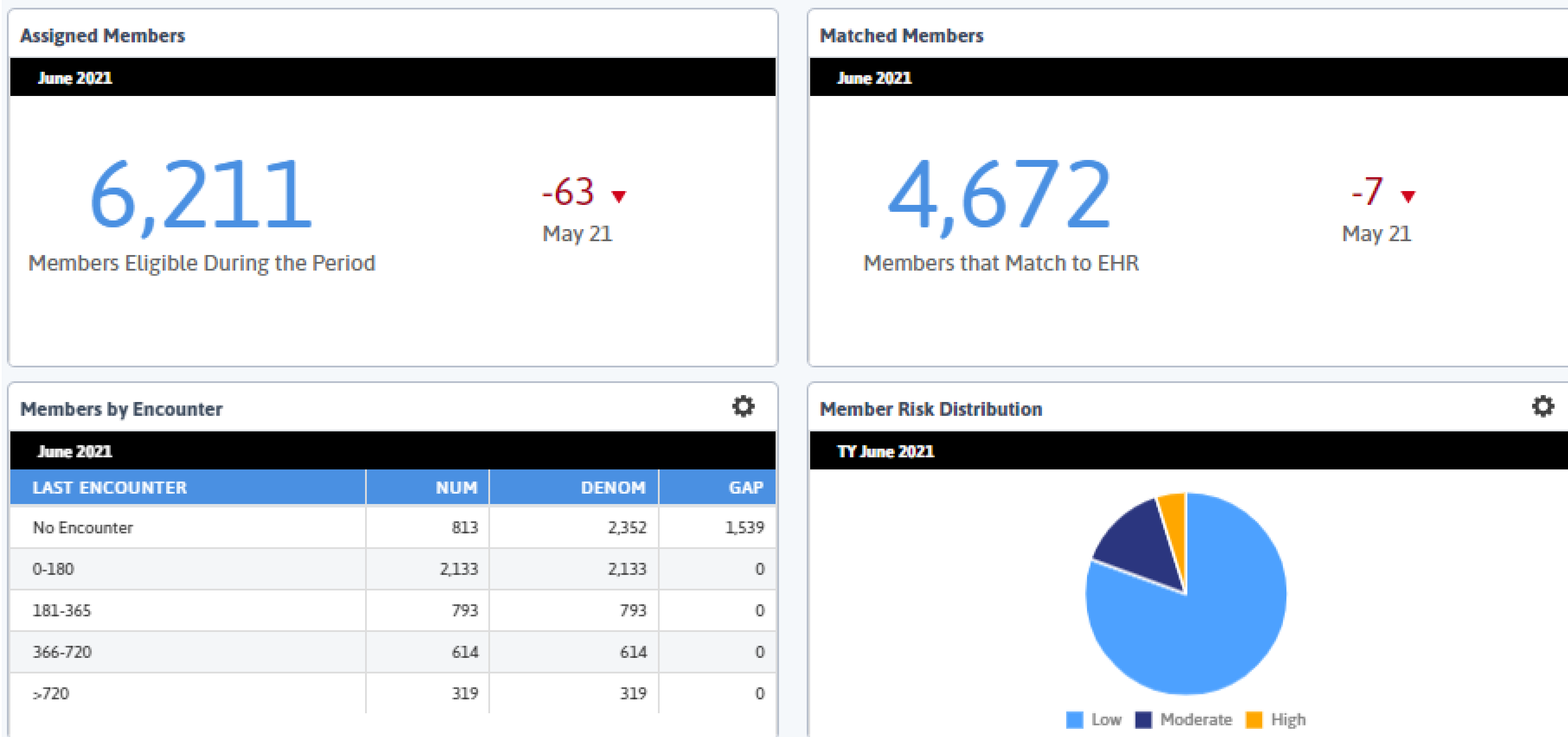
Measure Investigation Tool

MOST RECENT ENCOUNTER			NEXT APPOINTMENT					OUTPATIENT ENCOUNTER			
DATE	PROVIDER	LOCATION	DATE	PROVID...	LOCATION	NUMER...	EXCL...	DATE	CODE	COLONOSCO...	SIGMOIDOSCO...
2/5/2021											
6/15/2021											
10/16/2020											
6/8/2021											
6/10/2021											

Using Dashboards to Monitor Progress



Using Dashboards to Monitor Progress



LAST ENCOUNTER	NUM	DENOM	GAP
No Encounter	813	2,352	1,539
0-180	2,133	2,133	0
181-365	793	793	0
366-720	614	614	0
>720	319	319	0

Using Dashboards to Monitor Progress

Unmatched Members

June 2021

1,534

Members that do not Match to EHR

-38 ▼

May 21

Unmatched Members %

June 2021

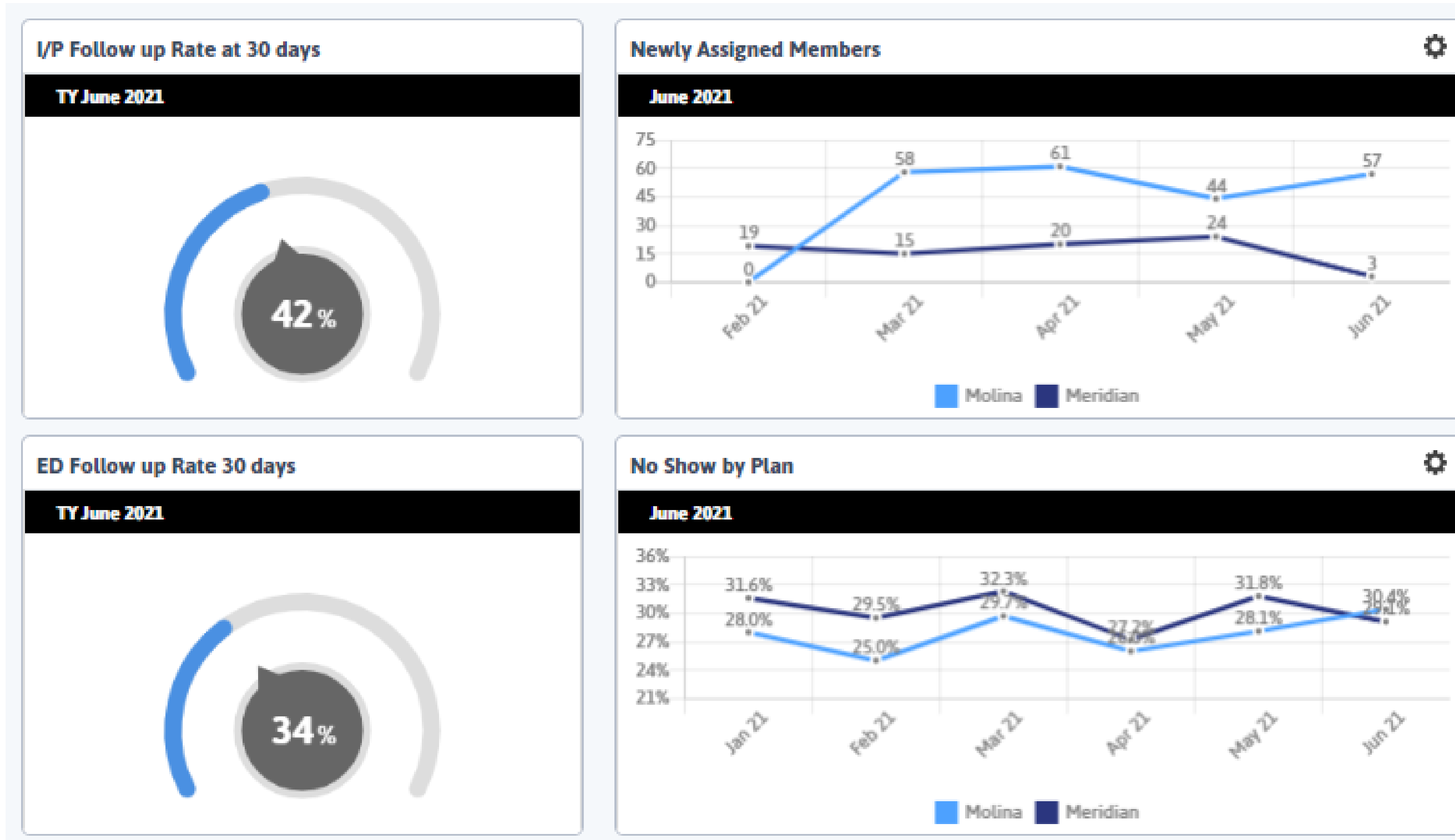
25 %

QI Indicators

TY June 2021

MEASURE		RESULT	CHANGE	NUM	DENOM	EXCL	GAP	2TGT
DM A1c Tested (1 yr)	●	89.8%	-0.6%	193	215	0	22	0
Chlamydia Screening for Women	●	63.8%	+8.0%	118	185	0	67	0
Cervical Cancer Screening	●	73.2%	+0.3%	673	919	30	246	182
Breast CA Screening Ages 50-74	●	51.9%	+6.3%	122	235	1	113	59
Colorectal Cancer Screening	●	30.9%	+2.2%	134	433	1	299	174

Using Dashboards to Monitor Progress



Resources: Tools for Luma Health

- Step-by-step visual guide to sending broadcast messages with Luma Broadcast
- Step-by-step visual guide for sending individual text messages with Luma Collaboration Hub (coming soon)
- Guidance on creating forms in Luma Health
- Integration with Azara DRVS (video available)

Questions?

Contact

Candy Vertalka
cvertalka@mpca.net

Or

Cheryl Gildner

cgildner@mpca.net

Our mission is to promote, support and develop comprehensive, accessible and affordable community-based primary health care services to everyone in Michigan.

WELCOME

Driving Change Through Patient and Family Engagement

July 13, 2021

Judith Gaudet

Systems of Care Director

GENERATIONS
FAMILY HEALTH CENTER

What Should Be Considered When Driving Effective "Patient Change Areas"?

1. Which Aim are we trying to affect?
2. Was there consideration of patient and family values, preferences and expressed needs?
3. Were patient and family voices part of the decision-making process?
4. In what ways were patients and families involved in the PDSA of the intervention/program?
5. Where patient and family voices heard in the evaluation and implementation of the change?

Site Code:

Provider Code:

Patient Satisfaction Survey With Services

Thank you for taking a few minutes of your time to complete this survey. Our healthcare teams want to provide quality care to you, our patient. It is very important to us that we meet your healthcare needs. Your name is optional on the bottom of the form and your responses to all questions are appreciated.

Are you a parent or guardian of the patient being seen today? ❑ Yes ❑ No

What is the Patient's age?
❑0 to 17 ❑18 to 24 ❑25 to 34 ❑35 to 44 ❑45 to 54 ❑55 to 64 ❑65 to 74 ❑75+

Gender: ❑ Male ❑ Female ❑ Other

Please respond to the statements below:	(4) Always	(3) Usually	(2) Sometimes	(1) Never
1) I was able to obtain an appointment to meet my needs.				
2) I was able to ask questions that were answered to my satisfaction.				
3) I trust my health information is protected within the electronic system.				
4) I found the building clean, comfortable and accessible.				
5) I receive timely responses to my test results.				
6) I received information about my responsibility for payment of services.				
7) I was treated respectfully during:				
• Telephone conversations when calling into the office.				
• Check-in				
• My time with clinical staff				
• Check-out				
• Other services/programs (ie: insurance/Food Stamps/Referrals.)				

What is your opinion regarding the following questions?	Yes	No	Comment (use other side as needed)
1) Should we expand hours of patient care at this office?			
2) Should we provide more patient education? If yes: List desired topics.			
3) Should we provide Specialty services such as:			
• Other (please specify)			

I would recommend Generations to family/friends. ❑ Yes ❑ No
Please explain:

Please use the back of this page to provide any additional comments and suggestions you may have.

❑ Please check if you would like us to contact you about your survey responses.

Name (*Optional*)

Phone No: (*Optional*)

E-Mail: (*Optional*)

Please return to receptionist at the end of your visit.

- **Multiple patient complaints across the organization regarding access to appointments.**
- **Frequent discussion among patient board members regarding the same issue.**
- **Patient survey administered to determine needs for expanded hours of operation.**

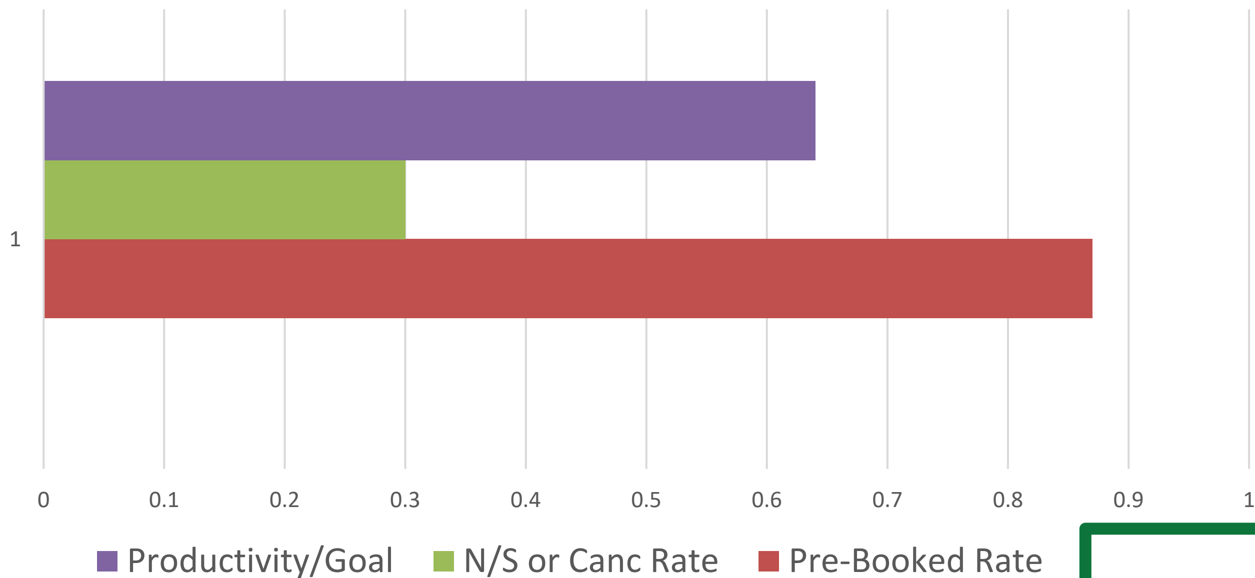
What is your opinion regarding the following questions?	Yes	No	Comment (use other side as needed)
1) Should we expand hours of patient care at this office?			

Patient Comments/Observations on Expanded Hours

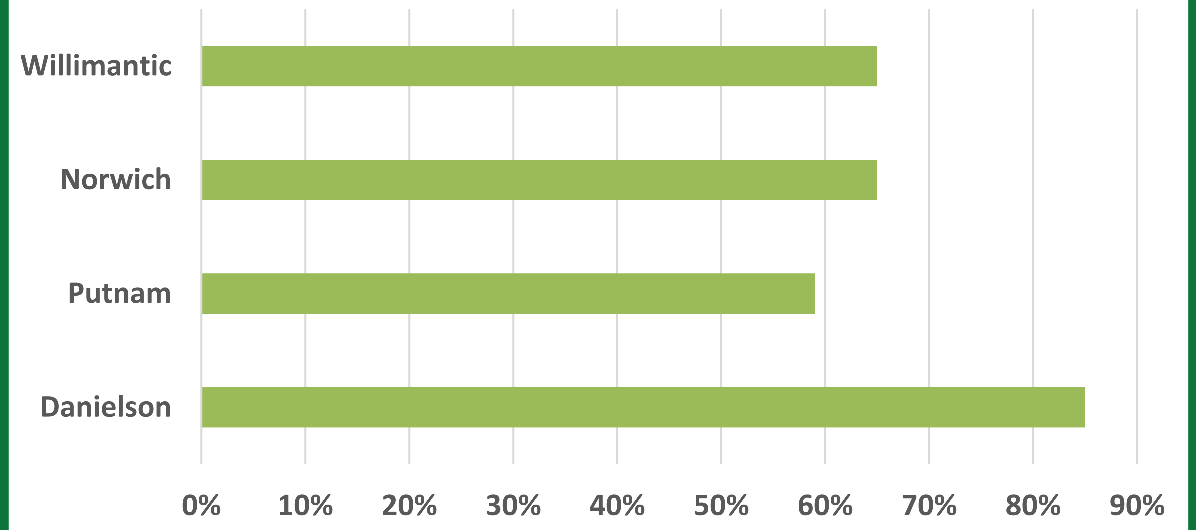
Medical – 45% indicated hours should be expanded and 8% respondents made related comments:

- Fines de semana y horas despuse de 5 p.m. (Weekends and hours after 5:00 p.m.)
- Weekends
- Works for me
- IDK (I do not know)
- Sometimes I have other appointments
- Hours are fine
- The only problem is no access on weekends and long waits.
- We all have different needs
- Earlier hours

- **Hours were extended Monday thru Thursday to accommodate appointments before and after work schedules**
- **We began a 6-month performance improvement project to determine if Saturday appointment availability was needed or would be utilized by patients and be sustainable.**



- **We were able to pre-book just under 90% of available Saturday appointment times.**
- **Higher than usual no show rate at 30%**
- **Met 64% of Overall Productivity Goal**



Site Code:_______ Provider Code:________

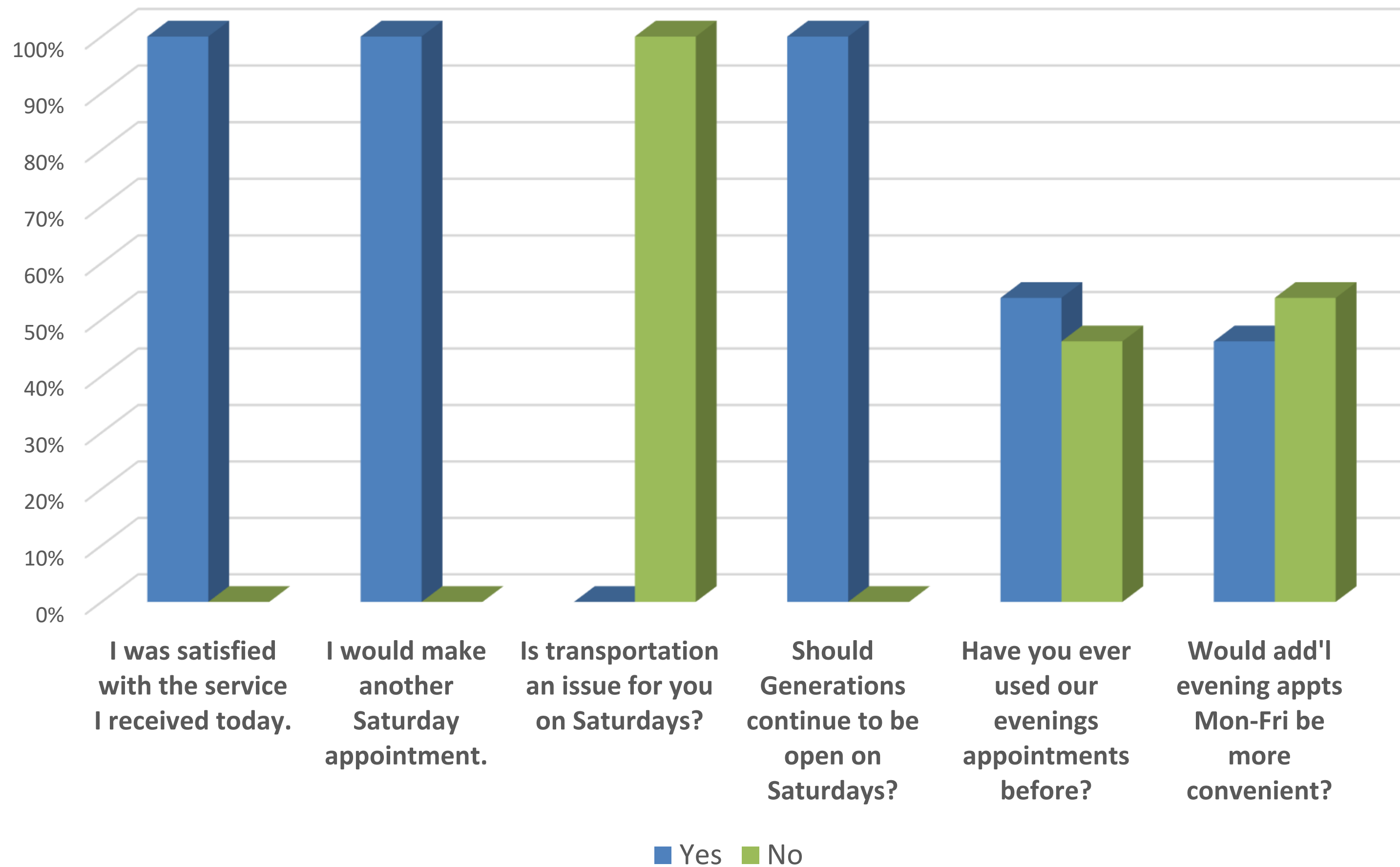
Patient Satisfaction Survey - Saturday Services

Thank you for taking a few minutes of your time to complete this survey. Our healthcare teams want to provide quality care to you, our patient. It is **very** important to us that we meet your healthcare needs. Your name is option

What is the Pa
❑0 to 17 ❑1

Please respond
1) I was satisf
2) I would ma
3) Is transpor
4) Should Ge
5) Have you e
6) Would add more conv

Please use this



A survey measuring *Patient Satisfaction with Saturday Hours* was created and administered during Saturday clinics.

Person and Family Engagement

Special Recognition is Hereby Given to

Generations Family Health Center

For **Excellence in Person and Family Engagement**

With sincere appreciation for your leadership in implementing Person and Family Engagement strategies to transform clinical practice and improve health outcomes.

2019

The expanded hours performance improvement project was submitted to CMS by Community Health Center Association of Connecticut as our Patient and Family Engagement Emerging Story submission as part of TCPI. We received an award in March 2019.

TCPI EXEMPLARY PRACTICE

Centers for Medicare and Medicaid Services

LETTER OF COMMENDATION

awarded to

Generations Family Health Center

On behalf of the Transforming Clinical Practice Initiative (TCPi) and the Centers for Medicare and Medicaid Services, I personally commend your practice for producing significant results in achieving the aims of TCPi. These aims reflect our combined commitment to high-quality, high-value care and improving the patient experience. Your practice's contributions to our collective achievement were critical to our success throughout the model. Due to your superior performance, the Community Health Center Association of Connecticut, Inc. Practice Transformation Network certifies your practice as a TCPi Exemplary Practice.

CMS recognizes your dedicated work and ongoing commitment to improving our nation's health. We appreciate your practice joining us in this growing movement. Thank you for pursuing this transformation journey with us and bringing quality improvement best practices to the forefront of our work.

Robert Flemming, PhD
Director, Transforming Clinical Practice Initiative
Centers for Medicare and Medicaid Services

July 15, 2019
Date

In July 2019, Generations graduated from the TCPI. Awarded the TCPI Exemplary Practice ***Letter of Commendation*** by Centers for Medicare and Medicaid Services.

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center

Camila Silva

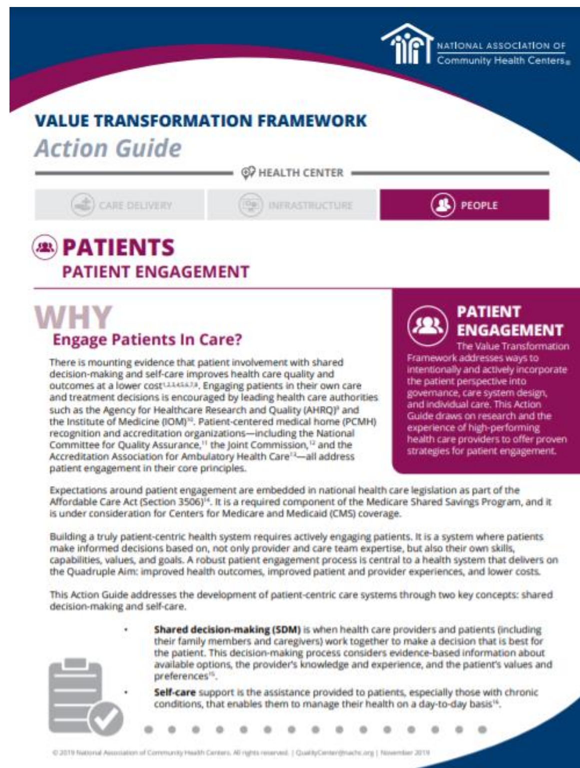
Manager, Quality Center
Training & Curriculum

Lizzie Utset

Specialist, Quality Center

Patient Engagement

Action Guide


NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

PATIENTS

PATIENT ENGAGEMENT

WHY Engage Patients In Care?

There is mounting evidence that patient involvement with shared decision-making and self-care improves health care quality and outcomes at a lower cost[1,2,3,4,5,6,7,8]. Engaging patients in their own care and treatment decisions is encouraged by leading health care authorities such as the Agency for Healthcare Research and Quality (AHRQ)[9] and the Institute of Medicine (IOM)[10]. Patient-centered medical home (PCMH) recognition and accreditation organizations—including the National Committee for Quality Assurance,[11] the Joint Commission,[12] and the Accreditation Association for Ambulatory Health Care[13]—all address patient engagement in their core principles.

PATIENT ENGAGEMENT The Value Transformation Framework addresses ways to intentionally and actively incorporate the patient perspective into governance, care system design, and individual care. This Action Guide draws on research and the experience of high-performing health care providers to offer proven strategies for patient engagement.

Expectations around patient engagement are embedded in national health care legislation as part of the Affordable Care Act (Section 3506)[14]. It is a required component of the Medicare Shared Savings Program, and it is under consideration for Centers for Medicare and Medicaid (CMS) coverage.

Building a truly patient-centric health system requires actively engaging patients. It is a system where patients make informed decisions based on, not only provider and care team expertise, but also their own skills, capabilities, values, and goals. A robust patient engagement process is central to a health system that delivers on the Quadruple Aim: improved health outcomes, improved patient and provider experiences, and lower costs.

This Action Guide addresses the development of patient-centric care systems through two key concepts: shared decision-making and self-care.

- **Shared decision-making (SDM)** is when health care providers and patients (including their family members and caregivers) work together to make a decision that is best for the patient. This decision-making process considers evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences[15].
- **Self-care** support is the assistance provided to patients, especially those with chronic conditions, that enables them to manage their health on a day-to-day basis[16].

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https://bit.ly/VTF_Patients

Actions

STEP 1 Identify a Patient Engagement Lead

STEP 2 Establish Patient Engagement Metrics

STEP 3 Use Daily Huddles to Support Patient Engagement

STEP 4 Enhance Patient Communication Skills

STEP 5 Provide a Written Care Plan or Visit Summary

STEP 6 Use Patient Decision Aids

STEP 7 Train Staff in Patient Engagement

Resources

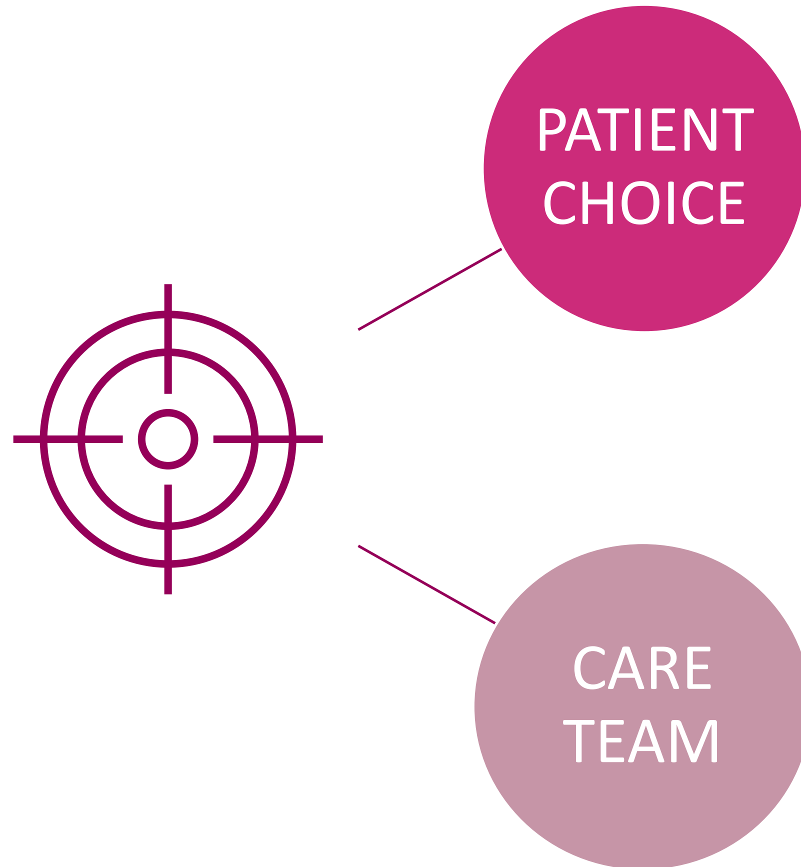
Pre-Appointment Patient Questionnaire

Ask-Tell-Ask method

Patient Experience Survey

Action Plan

Key Points



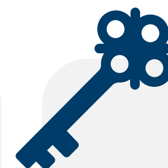
Patients make choices based on how staff make them feel, not just the quality of care provided.

Each member of the care team should have 'patient engagement' as part of their job role and task list.

Key Concepts

SHARED DECISION-MAKING

When health care providers and patients (including family/care givers) work together to make a decision.



SELF-CARE

Patients have the information and support needed to manage their health on a day-to-day basis.

New NACHC Infographic

https://bit.ly/VTF_Patients-graph

1 Identify a patient engagement lead

2 Establish patient engagement metrics

3 Use daily huddles to support patient engagement

4 Enhance patient communication skills

5 Provide a written care plan or visit summary

6 Use patient decision aids

7 Train staff in patient engagement

NATIONAL ASSOCIATION OF Community Health Centers®

Step 1:

Identify a Patient Engagement Lead

A key member of the staff responsible for maintaining an organizational focus on patient engagement and experience

- Director of Patient Experience
- Manager of Patient Engagement
- Member Experience Director

Step 2:

Establish Patient Engagement Metrics

- Measurement of "*Patient Experience*" central to the Quintuple Aim
- Central to HRSA Compliance Requirements and PCMH

INSERT LOGO HERE

AMA | STEPS*forward*

Patient experience survey: How are we doing?

We thank you in advance for completing this questionnaire. Our practice values your opinion and is dedicated to delivering quality care to all of our patients. Your answers help us improve the care we deliver to you and your loved ones.

Background:

1. If someone other than the patient is completing this survey, please check here. ☐
2. Was this your first visit to our practice? ☐ Yes ☐ No
3. How would you rate your appointment scheduling experience?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good

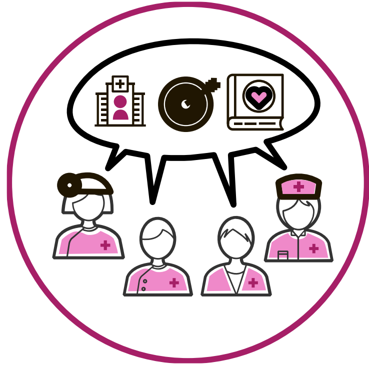
Moving through your visit:

4. How would you rate the courtesy of the front desk staff?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good
5. How would you rate your wait time before seeing the provider?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good
6. How would you rate the cleanliness of our practice?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good
7. How would you rate our concern for your privacy?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good

Your care team:

8. How would you rate the friendliness and courtesy of the nurse/assistant?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good
9. How would you rate the friendliness and courtesy of the care provider?
   ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good
10. How would you rate the amount of time the care provider spent with you?
    ☐ Very Poor ☐ Poor ☐ Fair ☐ Good ☐ Very Good

https://edhub.ama-assn.org/steps-forward/module/2702560#resource



Step 3:

Use Daily Huddles to Support Patient Engagement

AMA | STEPSforward

Team huddle checklist

Use this modifiable checklist to lead your team through efficient, effective huddles at the beginning of the clinic day or session.

Date:	Start time:
Huddle leader:	
Team members in attendance:	
Check in with the team	
	How is everyone doing?
	Are there any anticipated staffing issues for the day?
	Is anyone on the team out / planning to leave early / have upcoming vacation?
Huddle agenda	
	Review today's schedule
	Identify scheduling opportunities • Same-day appointment capacity • Urgent care visits requested • Recent cancellations • Recent hospital discharge follow-ups
	Determine any special patient needs for clinic day • Patients who are having a procedure done and need special exam room setup • Patients who may require a health educator, social work or behavioral health visit while at the practice • Patients who are returning after diagnostic work or other referral(s)
	Identify patients who need care outside of a scheduled visit
	Determine patient needs and follow up • Patients recently discharged from the hospital who require follow up • Patients who are overdue for chronic or preventive care • Patients who recently missed an appointment and need to be rescheduled
	Share a shout-out and/or patient compliment
	Share important reminders about practice changes, policy implementation or downtimes for the day
	End on a positive, team-oriented note • Thank everyone for being present at the huddle
	Huddle end time:

Anticipate patient needs:

- Brief (5 -15 mins)
- In-person
- Involve the right people
- Scheduled (consistent time)
- Convenient location

https://edhub.ama-assn.org/steps-forward/module/2702506#resource

Step 4:

Enhance Patient Communication Skills

Ask patients what they want to accomplish at their visit: Pre-Appointment Patient Questionnaire

Practice reflective listening: Ask-Tell-Ask method.

- **Ask** for permission to share information
- If permission is given, provide information: **Tell**
  - Consider patient's language and culture
  - Share information in small bits
  - Use pictures and decision tools
- **Ask** if patient understands information
  - This is an approach for "closing the loop" or "teach back

Step 5:

Provide a Written Care Plan or Visit Summary

Include self-care goals arrived at through shared decision-making

Action Plan

1. Goals: *Something you WANT to do:*
2. Describe
   How:
   Where:
   What: Frequency:
   When:
3. Barriers:
4. Plans to overcome barriers:
5. Conviction ___ & Confidence ___ ratings (0 - 10)
6. Follow-Up:

VISIT SUMMARY

Key points we discussed today:
Your blood pressure is 150/90.
Your goal is less than 130/85.
Dietandexercisearekeytocontrollingyourhypertension.

New medications:
benazepril (Lotensin)10 mg - one tablet per day

tructions:
ke your new pill when you first get up in the morning.
lk around the block every morning.
k around the block every afternoon.
ack on salt and alcohol.
back for a follow-up visit in 2 weeks.
ffice if symptoms worsen or if you have any questions.
nith, MD 9 / 6 / 06
Date

http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx

Step 6:

Use Patient Decision Aids

Paciente:______________________

IMPORTANTE

Fecha: ______________________

Como ***mujer de 50-75 años***, su médico quiere que usted reciba los siguientes chequeos basado en la *MEJOR INFORMACIÓN MÉDICA. Asegúrese de preguntar a su médico, enfermero profesional o asistente médico en la visita de hoy si usted necesita los exámenes que pueden ***salvar su vida*** ☺.

CONTROLES DE RUTINA:
- Presión sanguínea
- Chequeo de depresión
- Control de peso y orientación para un mejor control del peso
- Chequeo para el uso de aspirina o una medicación para bajar el colesterol para prevenir la enfermedad cardíaca

CHEQUEOS DE CÁNCER:
- Cáncer de mama (mamografía cada 1-2 años)
- Cáncer cervical (prueba Pap cada 3 años en mujeres de 21-65 años o cada 5 años en mujeres de 30-65 años que se realizan una prueba Pap y de HPV.
- Cáncer de colon (prueba FIT anualmente u otras pruebas de chequeo/diagnóstico y la frecuencia depende del riesgo)

ANÁLISIS DE SANGRE:
- HbA1c para diabetes
- Prueba de Hepatitis C
- VIH
- Enfermedades de transmisión sexual

ESTILO DE VIDA:
- Uso de tabaco
- Uso de alcohol
- Violencia en las relaciones

Patient Decision Aids

A systematic review/meta-analysis in Am J Prev Med 2016 article showed that patients “exposed to” decision aids for CRCS showed greater knowledge and were more likely to be screened: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5067222/

Step 7:

Train Staff in Patient Engagement

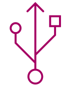
AHRQ toolkit to support training of health care professionals on how to engage patients in their health care decision making.

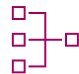
https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html

Future of Patient Care & Engagement

Patients as partners

Virtual Care

 Technology - such as machine learning and cloud computing

 Remote patient monitoring systems

Discussion

UPCOMING EVENTS

July 2021

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

13. Monthly Forum: Value Transformation & Patient Engagement

20. PCMH & Organizational Resiliency during the Pandemic ***(shifted to Sept 28th)***

21. Oral Health & Value Transformation, Part 1

28. Oral Health & Value Transformation, Part 2

August 2021

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

08. Monthly Forum: Care Management, Part 2 (Reimbursement)

Scan QR code to register

NEW OPPORTUNITY

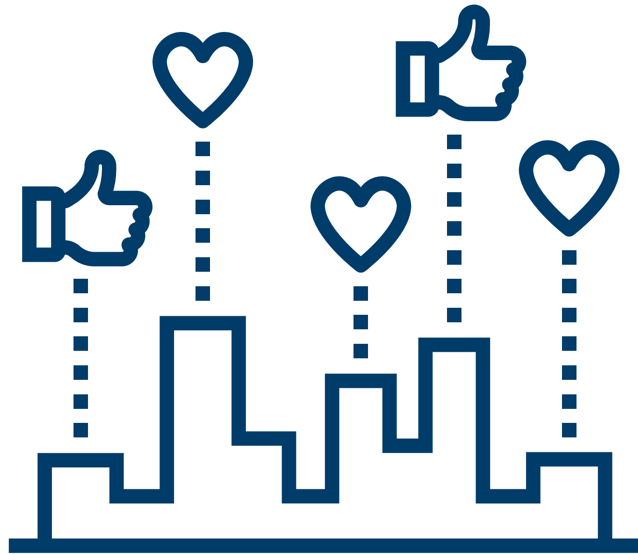
Request for Proposals:

Attention: PCAs/HCCNs/Health Centers/Others

NACHC Diabetes Prevention and Management Program: A National Virtual Model for Delivering the National Diabetes Prevention Program to Individual with/at-risk for Diabetes.

Deadline: July 30, 2021

https://www.nachc.org/about/current-rfps/



Provide Us Feedback

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

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Next Monthly Forum Call:

August 10th, 2021
1 -2 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

Together, our voices elevate all.

The Quality Center Team

Cheryl Modica, Luke Ertle, Camila Silva & Lizzie Utset

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