

### Patient and Family Engagement through a Health Equity Lens

Presented by: Jean Drummond HealthCare Dynamics International (HCDI) President



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Jean C. Drummond, President HealthCare Dynamics International



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# HCDI CORPORATE OVERVIEW



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### **HCD International Overview**

- HealthCare Dynamics, International founded and led by clinicians
- 25+ years delivering population health solutions
- 17+ years supporting CMS quality and population health programs
- **P3** Policy, Providers and People
- **National scale** and scope through community-based partnerships
- 75% of HCDI staff are clinicians, health care policy analysts, statisticians, communication specialists, consumer and community engagement experts, researchers
- NICHE: Policy to Practice Strategy focused on health care delivery systems and the quality/cost for vulnerable populations



### **HCDI Services**

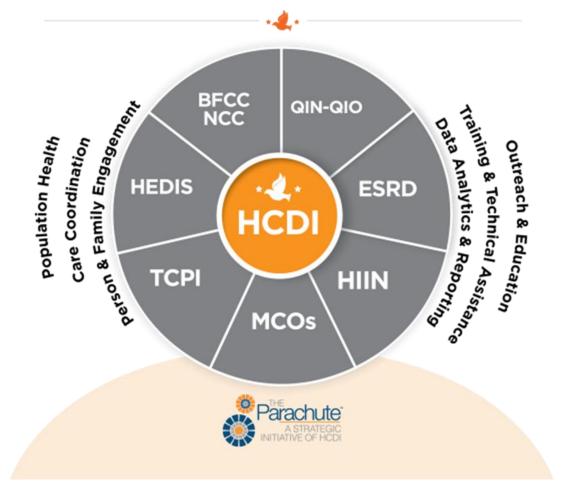
Health

- Healthcare Public Policy
- Population Health Management
- Data Analytics and Informatics
- Organizational Development and Training
- Social Marketing and Strategic Communications
- Graphic/Web Design and Development and Integrated Information Systems Solutions
- Health Information Technology



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#### HEALTHCARE DYNAMICS INTERNATIONAL'S (HCDI) CMS QUALITY INITIATIVES EXPERIENCE





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# **CURRENT ENVIRONMENT**



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### Understanding the Issues Facing the Healthcare Delivery System

Transformation of Health Care Delivery Systems

Alternative Financing Structure Driven by Quality

**Changing Demographics** 

**Geographic Vulnerabilities** 

High prevalence of Social Determinants of Health

**Unreachable Members (Non-compliant)** 

Lack of Person and Family Engagement



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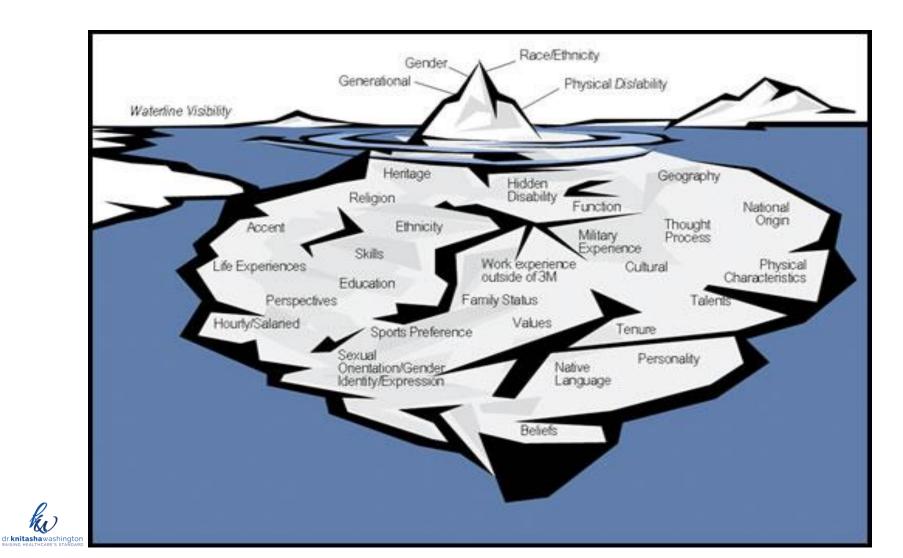


Health

Equity PFE



### **Iceberg of Culture**





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### Patient Safety and Healthcare Quality

Of the IOM's 6 Aims of Improvement:

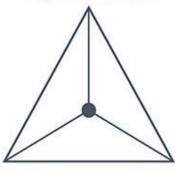
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- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable care has received the least attention.



**Population Health** 



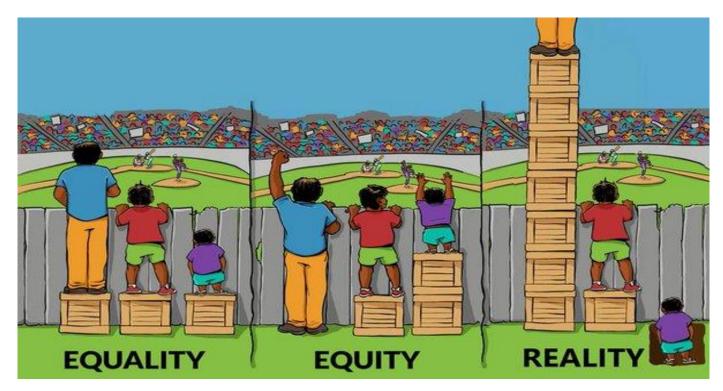
Experience of Care

Per Capita Cost





According to the Centers for Disease Control and Prevention Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."



http://interactioninstitute.org/illustrating-equality-vs-equity/



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# CHOC COMMUNITY CONSIDERATIONS



### **CHOC Pediatric Community Needs**

- Mental Health
- More Pediatricians and Pediatric Specialists
- Pediatric Obesity
- Resources for children with Autism Spectrum Disorders (ASD)
- Pediatric Dental Services
- Partnering/collaborating with other Agencies'
- Outreach to Schools
- Treatment for Alcohol and Substance Abuse
- Community Education
- Transportation Services



### **Understanding Patient and Practice Challenges**

### Patient Challenges

Health

- Low health literacy
- Lower household incomes
- Housing insecurity
- Lack of healthy food options
- Limited public and private transportation
- Co-morbid chronic conditions
- Live in vulnerable communities
- Limited access to a primary care provider
- Rare/non-existent specialty care
- Higher rates of substance abuse

Practice Challenges

- Time constraints
- Short supply of support staff
- Inadequate technology resources
- Small business framework
- Scarcity of trained workforce
- Unaware of frequent CMS updates
  and legislative changes
- Multiple sub-cultural health beliefs of patients
- Lack of patient compliance
- Trust concerns with government programs
- High number of uninsured patients



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# A CLOSER LOOK AT HEALTH EQUITY AND PFE







### Looking at Patient and Family Engagement Through Health Equity Lens

- What does this mean?
  - Understanding the measures/metrics set by healthcare/governmental entities may not be consistent/relative to each group.
  - Realizing there is no one size fits all approach to improving outcomes
  - Importance of identifying barriers in care and patient needs
  - Providing customized approaches to addressing these vulnerable populations

### Why is this important?

- We will continue to spend billions of dollars on healthcare if we don't start creating programs that are inclusive and promote health equity.
- How will it benefit the healthcare industry?
  - By addressing social determinants of health and creating synergistic relationships with community stakeholders to create programs we can improve health outcomes and increase cost savings.



### **CMS Patient and Family Engagement Metrics**

- Support for Patient Voices
- Shared Decision-Making
- E-Tools
- Patient Activation
- Health Literacy
- Medication Management



### **Support For Patient Voices**

It is important to have policies, procedures, and actions established to support patient and family participation in governance or operational decision-making of the practice. Examples of this:

- Person and Family Advisory Councils
- Practice Improvement Teams

Health

• Board Representatives, etc.







### Implementation of Health in All Policies



 Identify shared goals and co-benefits across sectors to build trust, enable partnership, and share successes and leverage them for ongoing work.



 Engage partners early and develop relationships; these efforts are essential in the planning, project development, or policy process.



 Define a common language across and within sectors to help remove communication barriers and allow partners to coordinate efforts around a place rather than a sector or agency.



 Activate the community to help frame the conversation and obtain community buy-in for planned approaches that make health a priority.



Leverage funding from complementary programs to support cross-agency efforts.



### **Shared Decision-Making**

The practice should support shared decision-making by training and ensuring clinical teams integrate:

- Patient-identified goals
- Preferences

Health

 Various concerns and desired outcomes into the treatment plan (e.g. those based on the individual's culture, language, spiritual, social determinants, etc.



### Tips for Shared Decision-Making

- 1. Invite the patient to participate
- 2. Present options
- 3. Provide information on benefits and risks
- 4. Assist patients in evaluating options based on their goals and concerns
- 5. Facilitate deliberation and decision making
- 6. Assist patients to follow through on the decision



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### Patient Connection to the Information (E-Tools)

Do clinicians serving vulnerable populations have the resources to promote or even utilize e-tools?

Things to consider:

- Access
- Availability
- Appropriateness
- Acceptability
- Applicability





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### **Patient Activation**

### Level 1

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## Disengaged and overwhelmed

Individuals are passive and lack confidence. Knowledge is low, goal-orientation is weak, and adherence is poor. Their perspective: "My doctor is in charge of my health."

### Level 2

## Becoming aware, but still struggling

Individuals have some knowledge, but large gaps remain. They believe health is largely out of their control, but can set simple goals. Their perspective: "I could be doing more."

### Level 3

### Taking action

Individuals have the key facts and are building self-management skills. They strive for best practice behaviors, and are goal-oriented. Their perspective: "I'm part of my health care team."

### Level 4

#### Maintaining behaviors and pushing further

Individuals have adopted new behaviors, but may struggle in times of stress or change. Maintaining a healthy lifestyle is a key focus. Their perspective: "I'm my own advocate."

### **Increasing Level of Activation**



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### **Health Literacy**

# patients with low HEALTH LITERACY...



## www.cdc.gov/phpr







### **Medication Management**

- The clinical team works with the patient and family to support their patient/caregiver management of medications?
- Are clinicians offering Accessing Pharmaceutical Assistance Programs (PAPs) to their patients?
- Are generic brands often recommended or requested?
- Do patients understand dosage recommendations?







### **Screening for Social Determinants**

- Ensure patient and family-centered screening for SDOH
- Integrate Screening with Referral and Linkage to community-based resources
- Perform Screening within the context of comprehensive systems approach
- Use a strength-based approach to support patients and their families
- Do not limit screening practices based on apparent social status



### **Asking the Right Questions**

What motivates you to be active in your health?

Health Equity PFE



Have you ever experienced harm or felt discriminated against while receiving care?





### Benefits of Screening & Asking the Right Questions

- Provide real-time opportunities to identify socio-economic factors that can affect the patient's clinical outcomes
- Assist in patient risk stratification
- Allow for documentation of the patient case complexity
- Reduce preventable hospitalizations and ER visits by providing early interventions
- Enhance care coordination practice management strategies
- Promote population management strategies to improve patient outcomes and enhance health equity



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### **How To Achieve Health Equity**

**Strategy 1:** Measurement and Research: Identifying and Understanding Disparities

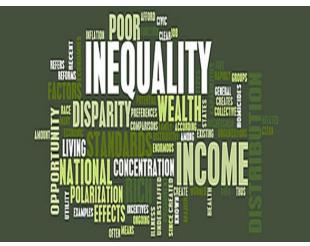
**Strategy 2:** Organizational Partnerships: Work with Diverse Partners to Identify Problems and Potential Solutions

**Strategy 3:** Care, Policy and Process Redesign: Adapting to Meet Identified Needs Better

**Strategy 4:** Clinician, Staff and Leadership Preparation: Delivering Patient-Centered Care

**Strategy 5:** Patient and Family Preparation: Empowering Patients to Engage Actively

**Strategy 6:** Transparency and Accountability: Communicating Openly and Consistently





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# THANK YOU VERY MUCH

### **Contact Information**

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