Session # ELO4

Implementing Family-Centered Care: Clinical, Operational, and Financial Perspectives

CFHA Oct 17, 2017 8:30AM – 11:30AM

Jennifer Hodgson, PhD, LMFT, East Carolina University

Alexandra Hulst, PhD, LMFT, Rocky Mountain Health Plans

Alan Lorenz, MD, University of Rochester, Rochester Institute of Technology

Randall Reitz, PhD, LMFT, St Mary's Family Medicine Residency

Andy Valeras, DO, MPH, FAAFP Dartmouth Hitchcock Leadership Preventive Medicine

Lisa Zak-Hunter, PhD, LMFT, The University of Minnesota

CFHA 21st Annual Conference
October 17-19, 2019 · Denver, CO

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2019

Slides and handouts are also available on the mobile app.

Faculty Disclosure

We have no financial disclosures to report.

Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Understand what it means to be culturally-informed family-centered advocates in primary care and the critical research that supports it.
2. Identify family-centered clinical interventions and operational-level strategies that can be used within the primary care context
3. Describe financial models for sustaining family-centered models in primary care.

Bibliography / Reference

Carman, K.L., Dardess, P., Maurer, M., Sofaar, S., et al., (2013). Patient and family engagement: A framework for understanding the elements and developing interventions and policies. *Health Affairs*, *32*, 223-231.

Leslie, L. K., Mehus, C. J., Hawkins, J. D., Boat, T., McCabe, M. A., Barkin, S., Perrin, E. C., Metzler, C. W., Prado, G., Tait, V. F., Brown, R., … Beardslee, W. (2016). Primary Health Care: Potential Home for Family-Focused Preventive Interventions. *American Journal of Preventive Medicine*, *51*(4 Suppl 2), S106-18.

Mendenhall, T., Lamson, A., Hodgson, J., & Baird, M. (2018). *Clinical methods in medical family therapy*. New York, NY: Springer.

Peek, C. J. (2008). Planning care in the clinical, operational, and financial worlds. In Collaborative Medicine Case Studies (pp. 25-38). Springer New York. https://doi.org/10.1007/978-0-387-76894-6_3

Ross, K. M., Gilchrist, E. C., Melek, S. P., Gordon, P. D., Ruland, S. L., & Miller, B. F. (2018). Cost savings associated with an alternative payment model for integrating behavioral health in primary care. *Translational Behavioral Medicine*, iby054. Doi: 10.1093/tbm/iby054

Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

What is the goal of Family-Centered Care?

To have…“patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct care, organizational design and governance, and policy making—to improve health and health care.”

Carmen et al., (2013)

What is Patient- and Family-Centered Care (PFCC)?

- …an approach to the planning, delivery, and evaluation of health care that…
  - promotes mutually beneficial partnerships among health care providers, patients, and families
  - redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, at all levels of care, and in all health care settings.
  - supports patients and families defining “family” and determining how they will participate in care and decision-making.
  - promotes the health, well-being, and autonomy of individuals and families
  - recognizes that patients and families are essential allies for quality and safety—not only in direct care interactions, but also in quality improvement, safety initiatives, education of health professionals, research, facility design, and policy development.

(IPFCC; Johnson & Abraham, 2012)

Core Concepts of PFCC

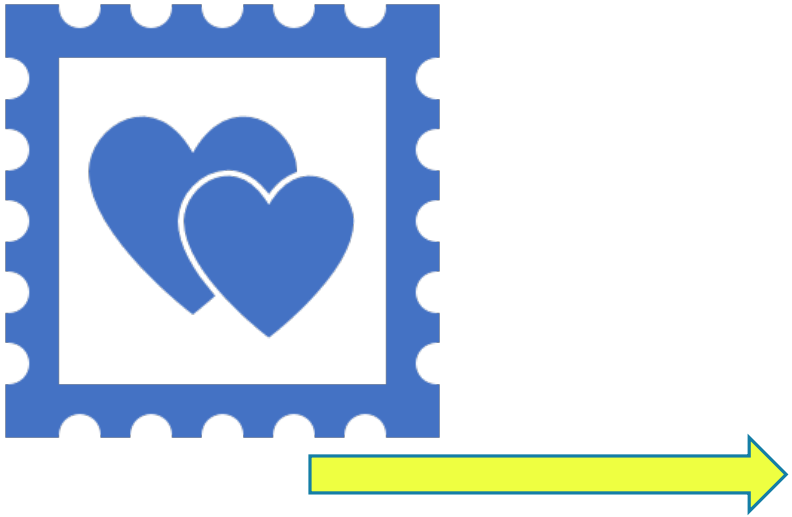
- **Dignity and Respect.** Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in research; in facility design; and in professional education, as well as in the delivery of care.

(Johnson & Abraham,

The constant variable…

(Johnson, 2000)

PFCC Core Concept: Dignity & Respect



- **Patient and family knowledge, values, beliefs and cultural backgrounds** are incorporated into the planning and delivery of care.
- …but ***how*** do we do this?
  - Practice with **cultural humility**
  - Promote agency and communion

Definitions

- *Cultural competence:*
  - " to be respectful and responsive to the health beliefs and practices—and cultural and linguistic needs—of diverse population groups." (SAMHSA, 2016)
- *Cultural awareness:*
  - Cognitive function (Hardy & Laszloffy, 1995)
  - Intellectual (Hardy & Laszloffy, 1995)
- *Cultural sensitivity:*
  - "Responds emotionally to stimuli with delicacy and respectfulness" (Hardy & Laszloffy, 1995, p.227)

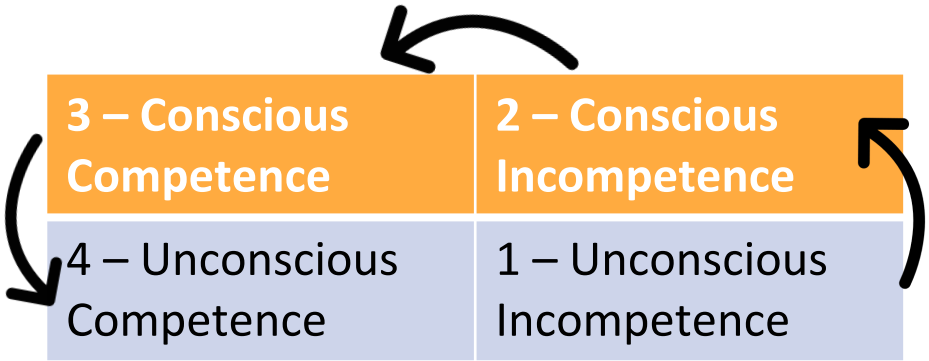
*****Can have cultural awareness without cultural sensitivity (Hardy & Laszloffy, 1995)

- *Cultural humility:* "personal awareness of beliefs and biases navigated over time" (Lewis et al., 2014, p. 325-326) with a purpose is to create space for the provider to understand themselves. It is a lifelong learning process with no achievable end.

What does it mean to practice with **cultural humility** and how do we get there?

Conscious Competence Model

- The progression is from quadrant 1 *through* 2 and 3 to 4.
- It is not possible to jump stages.
- For some skills, especially advanced ones, people can regress to previous stages, particularly from 4 to 3, or from 3 to 2, if they fail to practice and exercise their new skills.



(Gordon Training International Organization)

Conscious Competence Model

I am reading and learning more about my patients' social locations.

I am starting to see my cultural blindspots and biases

3 – Conscious Competence	2 – Conscious Incompetence
4 – Unconscious Competence	1 – Unconscious Incompetence

All my patients are the same

I routinely ask about how my patients' social locations and intersectionality impacts their health decisions and adjust their treatment plans collaboratively.

(Gordon Training International Organization)

Conscious Competence Model

Why is it important?

- People develop competence only after they recognize the relevance of their own incompetence in the skill concerned.
- Researchers have found that it takes 6 months to adopt a new habit!

1 – Unconscious Incompetence

- the person is not aware of the existence or relevance of the skill area
- the person is not aware that they have a particular deficiency in the area concerned
- the person might deny the relevance or usefulness of the new skill
- the person must become conscious of their incompetence before development of the new skill or learning can begin

(Gordon Training International Organization)

2 – Conscious Incompetence

- the person becomes aware of the existence and relevance of the skill
- the person is therefore also aware of their deficiency in this area, ideally by attempting or trying to use the skill
- the person realizes that by improving their skill or ability in this area their effectiveness will improve

(Gordon Training International Organization)

3 – Conscious Competence

- the person can perform it reliably at will and without assistance
- the person will need to concentrate and think to perform the skill - the skill is not yet 'second nature' or 'automatic'
- the person should be able to demonstrate the skill to another, but is unlikely to be able to teach it well to another person

(Gordon Training International Organization)

4 – Unconscious Competence

- the skill becomes so practiced that it enters the unconscious parts of the brain - it becomes 'second nature'
- common examples are driving, sports activities, typing, manual dexterity tasks, listening and communicating
- the person might now be able to teach others in the skill concerned, although after some time of being unconsciously competent the person might actually have difficulty in explaining exactly how they do it - the skill has become largely instinctual
- this arguably gives rise to the need for long-standing unconscious competence to be checked periodically against new standards

(Gordon Training International Organization)

Consider your own BPSS (triggers before working with others

- Biologically – physical
- Psychologically – mental
- Socially – family and friends
- Spiritually – beliefs and values

Engel, 1977, 1980; Wright, Watson, & Bell, 1996)

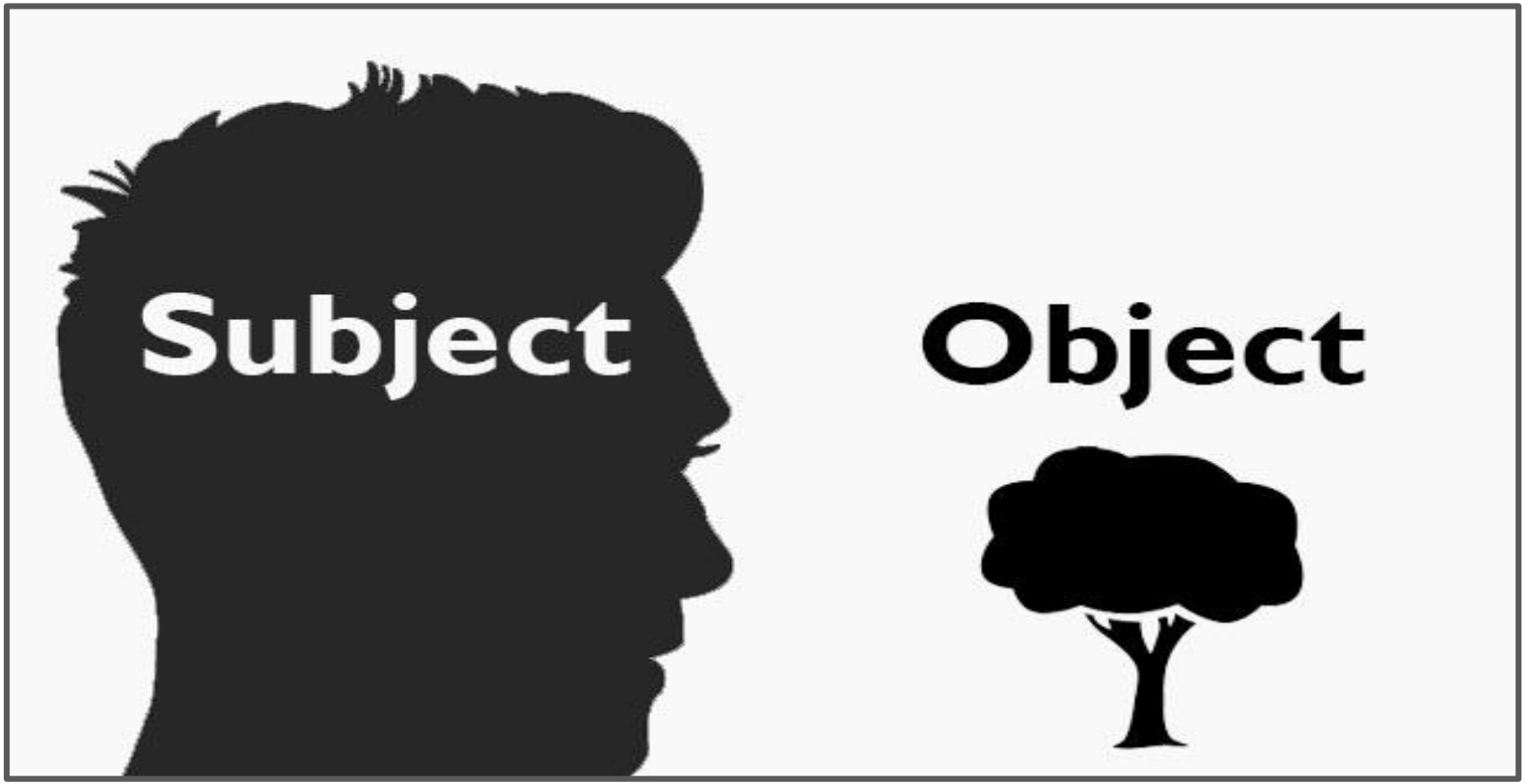
Training to think Systems

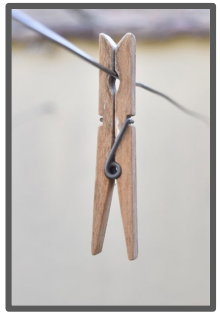
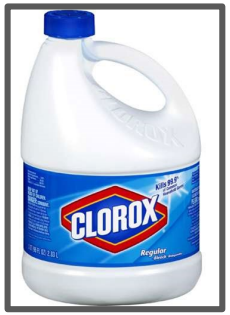
Mezirow's Definition of Transformative Learning

"The process of using a prior interpretation to construe a new or revised interpretation of the meaning of one's experience in order to guide future action"

Mezirow, 1991

Medical Model Paradigm






I am from





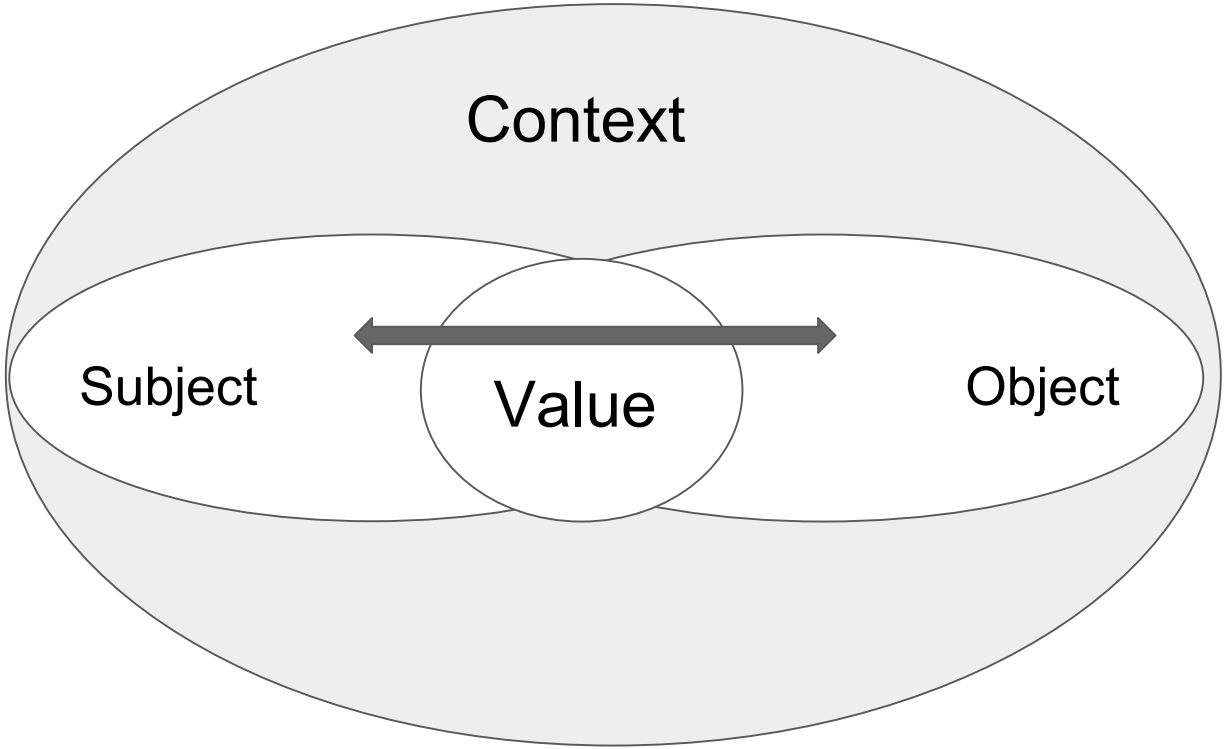
I Am From

Instructions

1. Complete the ”I am From” poem template.
2. Read aloud your poem to a partner.
3. Partner asks clarifying questions and shares reflections on poem.
4. Switch Roles
5. Reflect on “What did you learn through this process“.
6. Be prepared to share Learning Points with large group.

Time

- 5 min to complete poem
- 5 min each to share and reflect
- 5 min large group share



Alvaro Sylleros, Patricio de la Cuadra & Rodrigo F. Cádiz (2017) Understanding the Quality of Subject–Object Interaction: A Disciplinary Model for Design Validation, The Design Journal, 20:1, 67-86, DOI: 10.1080/14606925.2017.1252542

Before Asking is Awareness

Even well-intentioned comments and questions can be perceived negatively.

Addressing Social Locations

- Social location is a set of information that **determines an individual's place** within his/her community.
- All people have a social location that is defined by their **gender, race, social class, age, ability, religion, sexual orientation, socio-economic status, education and geographic location**.
- **Intersectionality** or social locations exist on a continuum (these are not binary conditions).

(Evans, 1979; Saker,

Being Family-Centered Advocates and attending to Social Locations

- Social location is a set of information that **determines an individual's place** within his/her community.
- All people have a social location that is defined by their **gender, race, social class, age, ability, religion, sexual orientation, socio-economic status, education and geographic location**.
- **Intersectionality** or social locations exist on a continuum (these are not binary conditions).

(Evans, 1979; Saker,

The Culturagram

Congress (1994, revised 2000) developed the *Culturagram* as a tool to assess and understand the complexities of culture and its impact on families; and increase sensitivity to the daily experiences of culturally diverse families.

Family Centered Care: Critical Research and Practical Applications

Lisa Zak-Hunter, PhD, LMFT
St. John's Family Medicine Residency
The University of Minnesota

Alan Lorenz, MD
RIT Student Health Center
University of Rochester, Rochester, NY

Areas of Research

How Families Affect Patient Health

How Patient Health Affects Families

Intervention Studies

How Do Families Affect Health?

Family Criticism/Conflict/Stress= Poor Outcomes

Migraines

Depression

Asthma

Weight Loss

Diabetes

How Do Families Affect Health?

Family involvement:

- Decreased mortality
- Reduced length of stay/readmission rates
- Improved treatment adherence
- Improved safety/quality
- Assist through healthcare system

How Do Partners/Couples Affect Health?

Poor Marital Quality → Poor Outcomes

How Do Partners/Couples Affect Health?

High Marital Quality=Improved Outcomes

- Increased immune function
- Pain reduction
- Faster recovery
- Self care
- Treatment adherence

How Does Health Affect Families?

Cancer
Pediatric cancer
Diabetes
Alzheimer's disease
Chronic pain
Hemodialysis

Stress
Depression
Sexual concerns
Conflict
Loneliness

Family Centered Intervention Studies

Information sharing**

Joint decision making

Participating in main care activities

Family Centered Intervention Studies

Family stress

Anxiety

Depression

Admissions

Readmissions

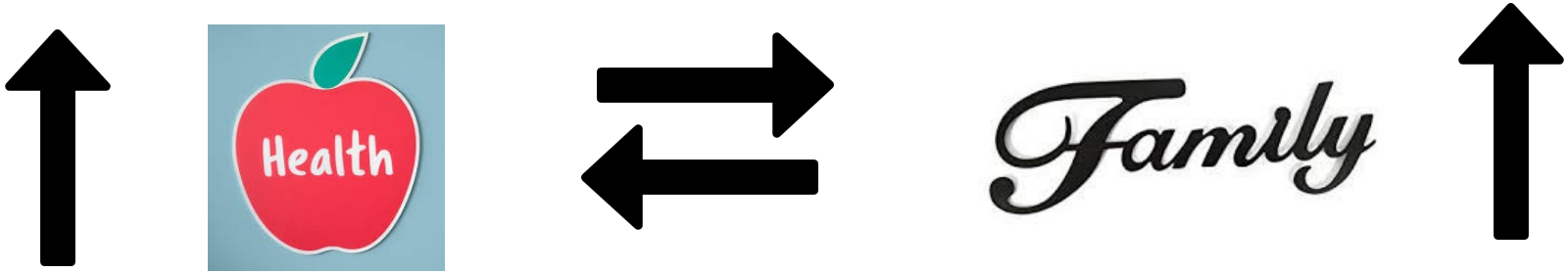
Length of hospital stays

Cost

Family Centered Intervention Studies

Family Centered Intervention Studies

Overall...



Practical Strategies for Family Centered Care

- Including Family when they are present
- Including Family when they are not present

Including Family in Care When They Are Present

- Introduction(s)
- Joining
- Soliciting Input
- Active Listening
- Strength Based & Solution Focussed
- Checking for Agreement

Including Family in Care When They Are Not Present

- Ask -- What do they think?
- Conjure -- If they were here, what would they say?
- Call -- Virtually always will answer
- Correspond -- Notes/Letters, Secure Messaging/E Mail
- Homework -- Ask patient to talk with them and get back to you

Potential Topics to Explore

- Family History of problem
- Family Explanatory Models – cause of problem, solutions
- Family Concerns – who is most concerned and in what way(s) are they concerned
- How has illness/problem Affected Family
- Family Strengths
- Family Support, Resources, and Help with problem

Geri-Ann Galanti's 4 C's

A mnemonic developed to help providers remember what questions to ask to gain insight into cultural diversity from the patient's perspective

- **C**all
- **C**ause
- **C**ope
- **C**oncern

Call

- What do you **CALL** your problem?
- “What do *you* think is wrong?”

Cause

- What do you think **CAUSED** your problem?
- This gets at the patient’s beliefs regarding the source of the problem.

Cope

- How do you **COPE** with your condition?
- “What have you done to try to make it better?”
- “Whom else have you been to for treatment?”
- “What effect has it had on your life/daily routine?”

Concern

- What **CONCERNS** do you have regarding your condition?
- “How serious do you think this is?”
- “What potential complications do you fear?”
- “How does it interfere with your life, or your ability to function?”

General guidelines for engaging the family

- Get consent from the patient
- Patient introduce the people in the room
- Engaging people across the lifespan is equally important
- Make good eye contact-look at each person present so everyone feels included
- Respect social locations and how they may impact engagement

Financial Sustainability for Family-Centered Integration

Randall Reitz, PhD, LMFT

St. Mary's Family Medicine Residency
Grand Junction, CO

Alexandra Hulst, PhD, LMFT

Rocky Mountain Health Plans
Grand Junction, CO

Clinic Perspective

We train family medicine residents

We train medical family therapists and social workers

We value comprehensive, family-oriented care across all settings

Our Mission

“Dedicated to the education of thriving health professionals and to promoting family wellness through high-value, comprehensive care.”


Advocacy with
leadership

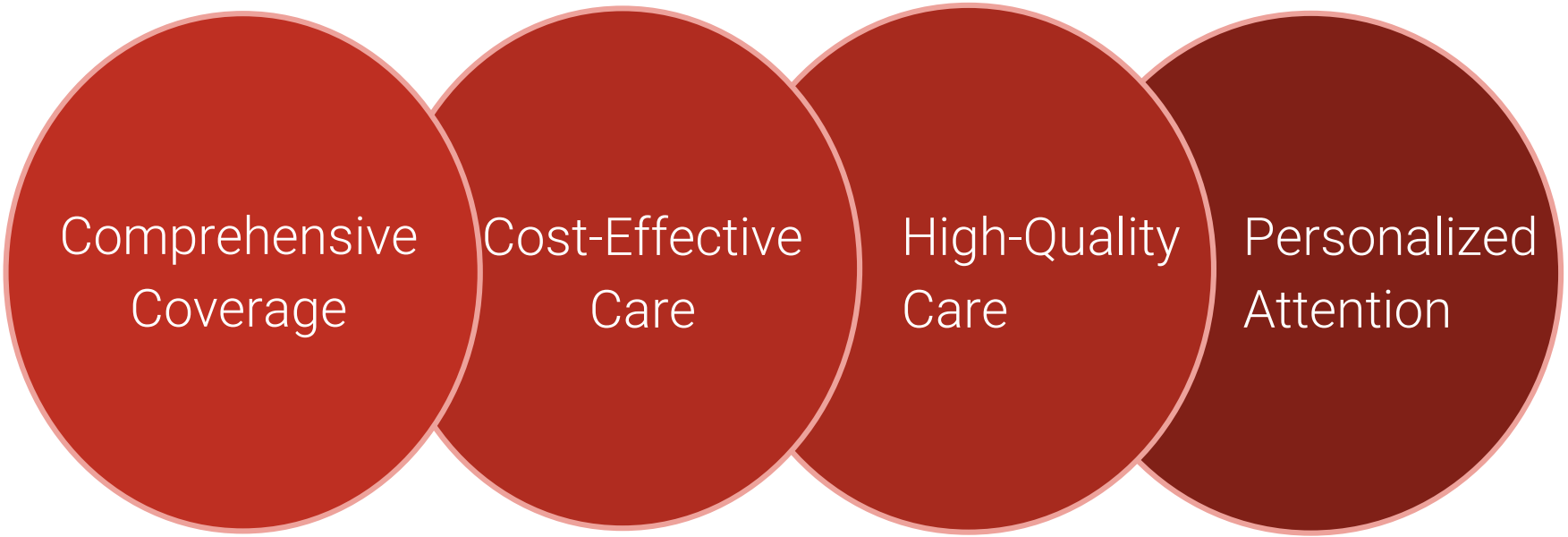
Writing off services for years

Payer Perspective

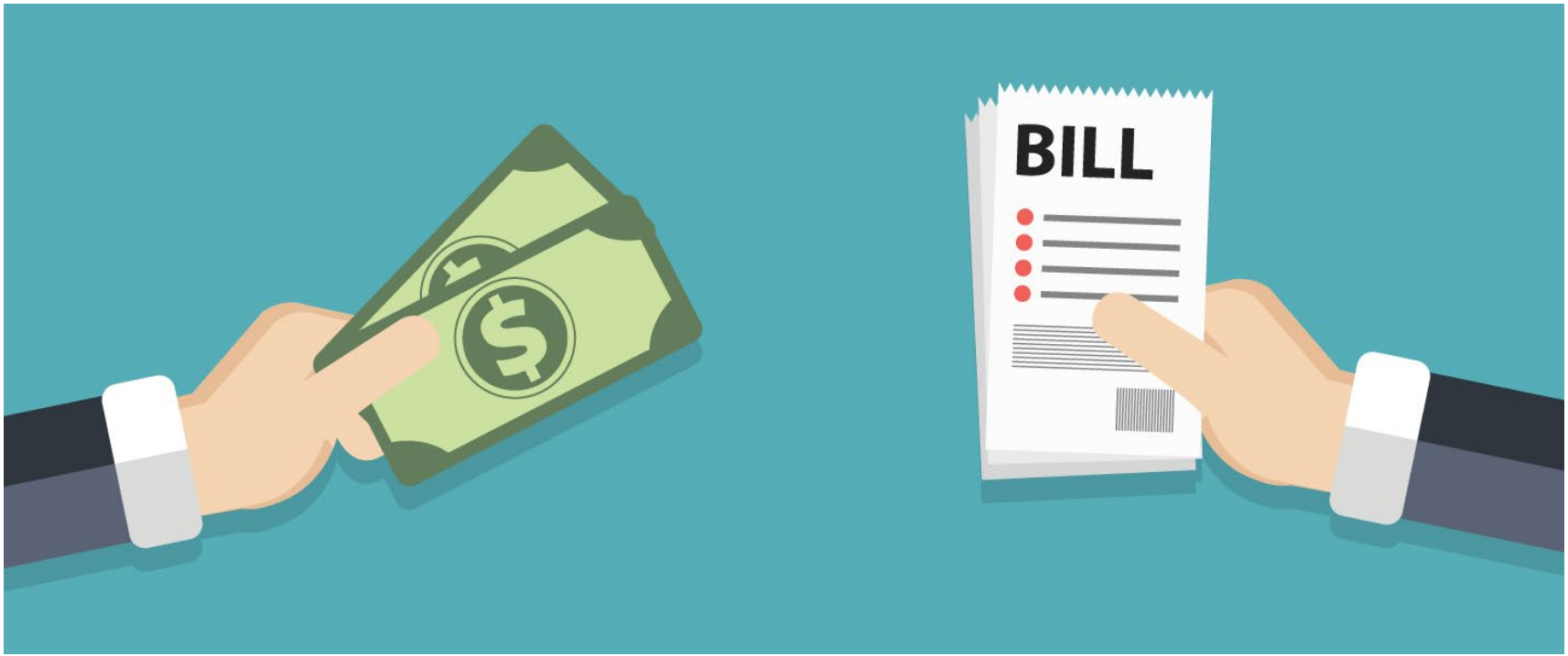
Our Mission

Rocky Mountain Health Plans takes the initiative to improve the lives of our Members and the health of our communities by offering innovative health plans, providing excellence in service, and staying true to our tradition of doing the right thing.

We Aim For...


Comprehensive Coverage
Cost-Effective Care
High-Quality Care
Personalized Attention

Examples of Family-Oriented Support (Payer)



Examples of Family-Oriented Support (Payer)

- Community Integration Agreements (CIAs)
- Community health workers (CHWs)
- Accountable Health Communities Model (AHCM)

Examples of Family-Oriented Support (Practice Transformation)

- Family-centered care sessions at learning collaboratives
- Language in Practice Transformation resource guides
- Promoting patient and family engagement

Examples of Family-Oriented Support (Care Management)

- Including family members in meetings
- Reducing impact of social factors interfering with health
- Joining medical visits for advocacy

Current staffing model

Director of Behavioral Medicine

MSW Student Intern

Clinical Pharmacist

Primary Care HIV Specialist

Behavioral Medicine Faculty

Doctoral Fellow

Addiction Medicine Specialist

Full-Time BHC

BSW Intern

Post-Masters Intern

Current staffing model

4 Care Coordinators

1 Community Health Worker

Sources of Revenue

CPC+

Value-based payment for Medicare, provides money to pay for all care coordinators, QI/Metrics manager, and parts of salaries for other positions.

RAE

As a Tier-1 site for the Medicaid behavioral health contract, we receive easy access to Medicaid billing and $150,000/year for staffing

GME

Requires behavioral medicine faculty, whose salaries are covered through RAE funds and appropriation of GME Medicare funds from the hospital.

HIV

HIV Clinic has state and federal contracts that cover all salaries

Addiction Clinic

Should be at least cost neutral based on billing of physician and IOP services

CHW

Community health worker paid for through funds from RMHP


Elevator
Pitch

Step 1

Know your payer’s pain points

- What are their biggest trends in potentially avoidable cost (PAC)?
- Where do they spend a lot of resources with internal staff time?

Step 2

Formulate your family-oriented pitch

- Evidence-based
- Population-specific
- Data-driven change
- Return on investment

What's the Evidence?

Condition	Sample References to Cite
Depression	Crane et al., 2012
Substance use disorders	Morgan and Crane, 2010
Diabetes	Fisher et al., 2000; Pereira et al., 2017; Trief et al., 2004
Schizophrenia	Christenson et al., 2013
Dementia	Mittelman et al., 2004
Sexual dysfunction	Fawcett & Crane, 2013
Pediatric chronic illnesses	Distelberg et al., 2016

Sample Clinical Quality Measures

- Diabetes control
- BH screening for foster children
- Follow-up with BH after positive depression screen
- Hypertension control
- Well child check rates
- Engagement in SUD treatment
- Depression remission

Sample NQF Measures

1333 **Children Who Receive Family-Centered Care**

STEWARD: The Child and Adolescent Health Measurement Initiative

Measure Description:

A composite measure designed to assess the family-centeredness of care delivery along several dimensions: whether doctor 1) partners with family in care, 2) listens to patient/parent carefully, 3) spends enough time with child, 4)is sensitive to family values/customs, 5) provides needed information, 6)whether family is able to access interpreter help, if needed.

Numerator Statement:

Percentage of children receiving Family-Centered Care (FCC)

Denominator Statement:

Children age 0-17 years with visit to a health care provider in last 12 months

Exclusions:

Excluded from denominator if child does not fall in target population age range of 0-17 years

Excluded from denominator if child did not see any health care provider in the past 12 months— preventive medical care, preventive dental care, mental health treatment or counseling, saw a specialist, or needed to see a specialist (K4Q20, K4Q21, K4Q22, K4Q23, K4Q25)

Sample NQF Measures

2844

VIEW THE NEW SPEC - *There is a new version under consideration.*

Family Experiences with Coordination of Care (FECC) -5: Care coordinator asked about concerns and health

STEWARD: Seattle Children´s Research Institute

Measure Description:

The Family Experiences with Coordination of Care (FECC) Survey was developed to gather information about the quality of care coordination being received by children with medical complexity (CMC) over the previous 12 months. The FECC Survey is completed by English- and Spanish-speaking caregivers of CMC aged 0-17 years with at least 4 medical visits in the previous year, and it includes all of the information needed to score 20 separate and independent quality measures, a sub-set of 8 of which are included in this submitted measure set. CMC are identified from administrative data using the Pediatric Medical Complexity Algorithm (PMCA)1, which uses up to 3 years' worth of International Classification of Diseases—9th Revision (ICD-9) codes to classify a child's illness with regard to chronicity and complexity. CMC are children identified by the PMCA as having complex, chronic disease.

The full NQF submission includes a set of 8 of the FECC quality measures; this submission relates to FECC 5, described below. The short descriptions of each quality measure follows; full details are provided in the Detailed Measure Specifications (see S.2b):

2842: FECC-1: Has care coordinator
2843: FECC-3: Care coordinator helped to obtain community services
2844: FECC-5: Care coordinator asked about concerns and health changes
2845: FECC-7: Care coordinator assisted with specialist service referrals
2846: FECC-8: Care coordinator was knowledgeable, supportive and advocated for child's needs
2847: FECC-9: Appropriate written visit summary content
2849: FECC-15: Caregiver has access to medical interpreter when needed
2850: FECC-16: Child has shared care plan

Each of the quality measures is scored on a 0-100 scale, with higher scores indicating better care. For dichotomous measures, a score of 100 indicates the child received the recommended care; a score of 0 indicates that they did not. Please see Detailed Measure Specifications (see S.2b) for additional measure-specific scoring information.

Where’s the Return on Investment?

↓ ER visits

↓ Preventable hospital admissions

↓ Total cost of care

↑ Quality metrics

↑ Patient & family satisfaction

Q & A
Summary

THANK YOU

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION