EXECUTIVE SUMMARY

PATIENT-CENTERED INTERACTIONS

Engaging Patients in Health and Healthcare

May 2013

What

Patient-centered interactions encourage patients to expand their role in decision-making, health-related behavior change, and self-management. Patient-centered practices respect patients' values and preferences, and this is reflected in the way the practice is designed. Communication is in a language and at a level the patient can understand, and data on patient demographics and preference is widely accessible. Principles of patient-centered care inform organization-wide decisions and interactions with individual patients.

Why

Patient-centered interactions engage patients with their own health and healthcare, resulting in patients having a better understanding of their health conditions and treatment. Collaborating with patients builds patients' skills and confidence in managing their health, especially for patients with chronic conditions. Patient-centered interactions also address the needs of patients with low health literacy. Patients with low health literacy are less likely to ask questions during care visits, seek health information from print resources, or understand medical terminology and jargon. Communication barriers can result in misunderstandings, care gaps, low-quality care, and poor health outcomes. Practices benefit from ensuring that all patients have the information and skills they need to manage their own care. Patients can also provide practices with valuable input and guidance on almost every aspect of care delivery.

Implementation Overview

Know your patient population

Gather data including primary language, cultural background, beliefs, needs, and preferences. Incorporate this information into decision-making and care redesign. Take into consideration the specific cultural and language needs of diverse patient populations.

- Gather feedback from patients and families using a variety of methods. Consider surveys, focus groups, and point-of-care assessments.
- If using a survey, consider whether the questions provide the information you need, the availability of benchmarking data, whether the survey has been used in a comparable population, and available languages.

Develop a relationship with patients.

- Show dignity and respect. Listen to and honor patient and family perspectives, choices, knowledge, values, beliefs, and cultural backgrounds.
- Share information. Communicate and share complete and unbiased information with patients and families in affirming and useful ways.
- Ask patients to complete a visit preparation or assessment form before the visit. Use that information to build a shared agenda for the visit with the patient. Open the conversation with the patient's concerns and experiences since the last visit. Focusing on a patient-identified health goal is more effective than mandating change.

Address communication barriers

Use plain language and teach-back techniques to assure you have delivered information in a way that patients can understand and use.

- Develop resources to communicate effectively with diverse patients.
- Elicit the patient's belief about health and healthcare.
- Consider patient literacy and health literacy levels when selecting or creating surveys and patient education materials.
- Use data about health literacy to inform visit structure.

Provide self-management support

- Systematically offer brief motivational interventions to develop patient-identified goals and action plans to improve health behaviors and outcomes.
- Use a team approach to support self-management before, during, and after the visit.
- Provide regular follow-up and problem solving, and link patients to community resources.

Collaborate with patients

Work with patients, families, and healthcare leaders in policy and program development, implementation, and evaluation; facility design; professional education; and delivery of care.

- Develop patient advisory groups to help guide and conduct quality improvement activities. Patients can draw on their own experiences of care at the facility to inform decisions about changes to care delivery.
- Provide guidance and support for advisory group members about medical culture, quality improvement methods and philosophy, the PCMH, confidentiality issues, understanding "medical-ese," and group dynamics, among others.
- Engage patient advisory group members in clinical team meetings, collaborative meetings, and advisory-group only meetings to discuss QI projects.

What Progress Looks Like: PCMH-A Level A

The PCMH-A a is self-assessment tool to help practices understand their current level of "medical homeness," identify opportunities for improvement, and track their progress toward practice transformation. It is also a learning tool that can help start conversations within a practice about patient-centered care. The PCMH-A is scored on a 1-12 scale, which is divided into four levels (D, C, B, and A). A "Level A" item score indicates that most or all of the critical aspects of the key change addressed by the item are well established in the practice. An overall Level A score indicates that the practice has achieved considerable success in implementing the key design features of the PCMH.

Level A PCMH-A Items

21. **Assessing patient and family values and preferences...**is systematically done and incorporated in planning and organizing care.

22. **Involving patients in decision-making and care…**is systematically supported by practice teams trained in decision-making techniques.

23. **Patient comprehension of verbal and written materials…**is supported at an organizational level by translation services, hiring multi-lingual staff, and training staff in health literacy and communication techniques (such as closing the loop) ensuring that patients know what to do to manage conditions at home.

24. **Self-management support…**is provided by members of the practice team trained in patient empowerment and problem-solving methodologies.

25. **The principles of patient-centered care…**are consistently used to guide organizational changes and measure system performance as well as care interactions at the practice level.

26. **Measurement of patient-centered interactions…**is accomplished by getting frequent and actionable input from patients and families on all care delivery issues, and incorporating their feedback in quality improvement activities.

Safety Net Medical Home Initiative

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The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado, Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S.

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