Pathways to Person-Centered Care

Building a Foundation to Successful Implementation

CQC
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Introduction

Health care organizations are increasingly recognizing that prioritizing the needs and wants of a person can be a path towards improved outcomes and patient experience. Providers want to deliver person-centered care, and intuitively recognize when they are doing so. However, providers can also be challenged to provide a concrete definition of "person-centered care", and to definitively demonstrate that they are delivering it.

The American Geriatrics Society released a definition of person-centered care that skillfully captures the important elements of person-centered care. What is now needed is a translation of these elements into operational changes in healthcare settings. For providers interested in implementing person-centered care, this tool breaks down the definition elements into manageable steps, that put together will lead to a transformation of care, to person-centered care.

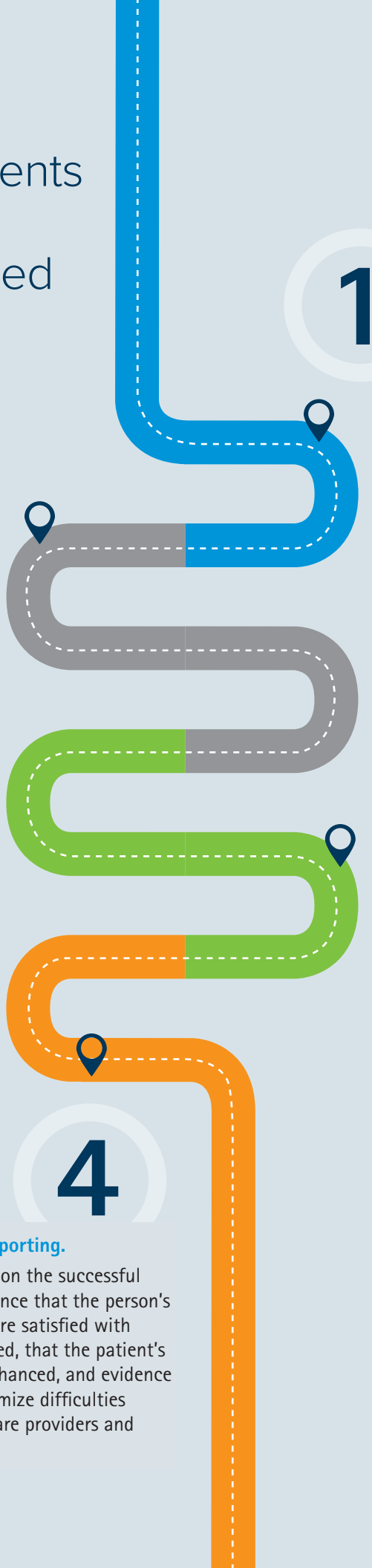
How to use this tool

This tool is intended to provide guidance to providers and care teams looking to improve their delivery of person-centered care. Recognizing that most teams have limits on time and resources, the tool is designed as a checklist offering a range of action steps. Providers and teams can choose action steps that are best suited for their setting, resource availability and team configuration.

On page four, The Basic Steps to Getting Started checklist groups action steps by the essential elements in the person-centered care definition. The checklist highlights as a starting point high priority items within each element, but teams can start work in any element to move on the path towards more person-centered care. The four elements can be implemented in any order or combination—the main objective is to select an action step and get started on the path to person-centered care.

To provide you with additional tools and resources for your move to person-centered care, there is a Resource list on page five. This list is just a sample of the many resources available—we encourage you to start with these resources and explore beyond them as much as possible as you learn more about your team's needs and capabilities.

Essential Elements to Realizing Person-Centered Care



1

Establish an individualized, goal-oriented care plan based on the person's preferences that is reviewed on an on-going basis.

Take time to listen to the person's story, including medical, functional and social needs and encourage them to express their health and life goals. The person's action plan should be realistic so that success is likely and hope kindled. Reassess the care plan on a regular basis to address the person's evolving health and life goals, and to incorporate changes in the person's medical, functional, psychological, or social status.

2

Ensure care is supported by a multi-disciplinary team that includes the person as an integral member. One care provider is the patient's primary point of contact, coordinating services and communication across the team.

The team must be flexible and adaptable to changes in the person's health status, circumstances, and care and life goals. Having one primary point of contact helps build trust, eases communication and facilitates continuity of care and transitions across care settings. Communication and information sharing may be accomplished through the use of the electronic health record or other electronic tools.

3

Education and training for providers and, when appropriate, the person and those important to the person.

Including the principles of person-centered care in the education and training of all healthcare providers contributes to their understanding of and commitment to providing person-centered care. Health education of people receiving care and those important to them supports informed decision-making and self-determination.

4

Performance measurement and reporting.

Measurable outcomes should focus on the successful implementation of care plans, evidence that the person's goals are being met and that they are satisfied with communication and services provided, that the patient's capacity for self-management is enhanced, and evidence that efforts are being made to minimize difficulties during transitions between healthcare providers and across care settings.

Implementing Person-Centered Care

Basic Steps to Getting Started

☐ Implement these action items first

Element 1

Establish an individualized, goal-oriented care plan based on the person's preferences that is reviewed on an on-going basis.

ACTION ITEMS	TO CONSIDER
☐ Identify at least one of the person's goals, with achievable steps towards the goal.	Goals can be clinical, social or behavioral. Action plans should start small, based on what is important to the person. This may be a different goal from the care team.
☐ Update the person's goals at regular interval (e.g. 6 months, 12 months or after an event such as hospitalization or change in prognosis).	When updating goals check for changes in medical, functional, psychological, and/or social status.

Element 2

Ensure care is supported by a multi-disciplinary team that includes the person as an integral member. One care provider is the patient's primary point of contact, coordinating services and communication across the team.

ACTION ITEMS	TO CONSIDER
☐ Identify a care coordinator as the main point of contact for the person.	Provide the person with the care coordinator's phone number and email address. Care coordinators can be non-licensed staff, including medical assistants and community health workers; the care coordinator forms a trusting relationship with the person and helps connect the person with other providers and resources.
☐ The care coordinator communicates across all care settings, including hospitals.	People may receive care from multiple providers requiring exchange of clinical information across providers. Ensure care coordinators and other team members receive timely notification of patient admissions, discharges and transfers.
☐ Care coordinator and rest of care team attend regular team meetings to update on status and assess changes.	Team members may change based on the person's needs—always be assessing who is most able to support the person.
☐ Involve the person's family or caretakers when possible.	With patient approval, share the care plan with the family and inform them of changes.

Element 3

Education and training for providers and, when appropriate, the person and those important to the person.

ACTION ITEMS	TO CONSIDER
☐ Providers are trained on principles of person-centered care.	To inform providers about patient preferences, interview five patients about their experience with health care, both good and bad, and share with the team.
☐ Providers/staff trained on motivational interviewing.	Providers need to be trained to assess a person's self-management capacity, to take time to listen to the person and to develop an achievable action plan with the person to enable success and build hope.
☐ Care team enables informed decision-making through continual communication with person, caregiver and family.	Make sure to review the benefits and risks of taking action and not taking action, e.g. for procedures, surgeries, medications.

Element 4

Performance measurement and reporting.

ACTION ITEMS	TO CONSIDER
☐ Document person's goals and care plan in EHR.	Ensure care team has access to EHR. If EHR access is not available, alternate communication channels are established and used.
☐ Select key metrics to determine how person-centered your program is.	Track as key metrics: • evidence that the person's goals are documented and are guiding care, • evidence that efforts are being made to minimize difficulties during transitions between healthcare providers and across care settings, • evidence that people are satisfied with communication with the team (e.g CollaboRATE survey). • evidence that programs are connecting with a significant number of target population, • evidence that self management is improving (e.g. using the Patient Activation Measure).

Resources

Element 1

Establish an individualized, goal-oriented care plan based on the person's preferences that is reviewed on an on-going basis.

RESOURCES

- The Playbook
  Play: Develop Coordinated Care Plans
  https://www.bettercareplaybook.org/plays/play-develop-coordinated-care-plans

- Agency for Healthcare Research and Quality
  Develop a Shared Care Plan
  https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan

Element 2

Ensure care is supported by a multi-disciplinary team that includes the person as an integral member. One care provider is the patient's primary point of contact, coordinating services and communication across the team.

RESOURCES

- The Playbook
  Play: Define the Care Management Team
  https://www.bettercareplaybook.org/plays/play-define-care-management-team

- Institute for Healthcare Improvement
  Workforce Development: Creating Effective & Resilient Teams to Care for Complex Patients
  http://www.careredesignguide.org/wp-content/uploads/2016/12/CareOregon__Workforce_Development.pdf

Element 3

Education and training for providers and, when appropriate, the person and those important to the person.

RESOURCES

- Behavioral Diabetes Institute
  Introduction to Motivational Interviewing: Simple Strategies for Promoting Positive Behavior Change in Diabetes
  https://behavioraldiabetes.org/audio-and-video-materials/#hcppresentations

- California Quality Collaborative
  Trauma Informed Care: Impact of Adverse Childhood Experiences
  http://www.viddler.com/v/cf8136c4

  Dementia Center Care: Supporting Cognition & Function in the Cognitively Impaired
  http://www.viddler.com/v/b0ca2568?secret=96453198

  The Case for Patient Activation: Research Findings & Real World Examples
  http://www.viddler.com/v/42eb395?secret=95237498

Element 4

Performance measurement and reporting.

RESOURCES

- Patient Activation Measure® (PAM®)
  https://www.insigniahealth.com/products/pam-survey

- PMC - US National Library of Medicine National Institutes of Health
  The Psychometric Properties of CollaboRATE: A Fast and Frugal Patient-Reported Measure of the Shared Decision-Making Process
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3906697/