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Communication Matters

Healthcare innovations fly under the radar

Change is in the air! The U.S. healthcare system is in the midst of far-reaching transformation. Every person and organization involved in any aspect of healthcare is affected by many and competing pressures. We are all challenged to improve patient and population outcomes, use rapidly advancing technology to best advantage, engage patients in decision-making, and adopt evidence-based practices-all while keeping cost growth under control.

IHC is proud to provide healthcare teams with critical communication skills to help team members navigate these turbulent times. We invite you to examine the context and content of our newly updated Team- and Patient-Centered Communication for the Patient Medical Home curriculum.

Warmly,

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While the public and the media focused on the chaos and confusion surrounding the roll-out of health insurance exchanges under the **Affordable Care Act** (ACA), an array of lower-profile reform efforts are underway. Some predate the ACA, while others are intrinsic to broad reform intentions in the law. In hospitals, medical practices, health systems and states across the country, experiments and planning processes are addressing some of the fundamental features of our healthcare system that contribute to high costs, uneven quality and access, and suboptimal population health outcomes. ***A number of these reform initiatives are closely aligned with IHC's mission: to advance the quality of healthcare by optimizing the experience and process of healthcare communication.***

Sizable, sustained investment

The range and reach of reform initiatives are impressive, with serious money flowing to these efforts. Just a few examples include: $2B for Health Care Innovation Awards, $22M for state-based Model Design Awards, more than $250M for state-based Model Testing Awards and $100M for selected states to address Medicaid Incentives for the Prevention Chronic Disease Models (Centers for Medicare & Medicaid Services 2014).

The federal government has defined most of these grant programs as medium-term efforts (3 years), and demands rigorous evaluation of the results in terms of quality, cost and feasibility. State-based projects are addressing payment incentives and population health goals.

Varied experiments

Federal Health Care Innovation Awards, given to individual provider organizations and networks of providers, support experiments with a variety of "new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest healthcare needs" (Centers for Medicare & Medicaid Services 2014). Initiatives vary from community-wide efforts to reduce inappropriate imaging in Michigan to a Maryland hospital's plan to create a Patient-Centered Medical Home for high-risk Medicare beneficiaries, to a Wisconsin multi-provider effort to create an "Advanced Wrap Network" Model to increase the use of primary care health homes. A number of initiatives target reduced emergency room use and hospital readmissions, and other communities are addressing the need to enhance access for low income and/or rural residents. Several projects are focused on improving access to mental health services and coordination with primary care.

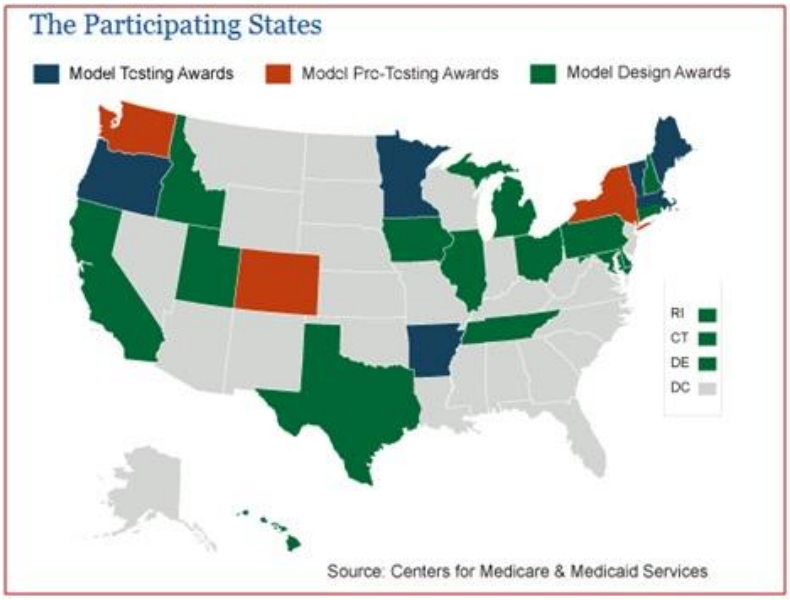
> In addition to programmatic initiatives, CMS is testing the efficacy of a payment model that permits greater flexibility in the care of Medicare recipients. A large number of Federally Qualified Health Centers (474 FQHCs) are part of a demonstration project to pursue Advanced Primary Care, in which healthcare teams coordinate the care for 195,000 Medicare enrollees. "Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition, help patients manage chronic conditions, as well as actively coordinate care for patients. To help participating FQHCs make these investments in patient care and infrastructure, they will be paid a monthly care management fee for each eligible Medicare beneficiary receiving primary care services. In return, FQHCs agree to adopt ***care coordination practices*** that are recognized by the National Committee for Quality Assurance (NCQA)" (Centers for Medicare & Medicaid Services 2011).

Every federally funded project under this section of the ACA is required to report on its results: how well it has achieved its goals, its costs, resulting savings, and implementation issues. Over the next few years, there will be a flood of information about the efficacy and efficiency of these-and other-experiments.

States as health reform laboratories

State-based health system reform initiatives funded by the ACA are active and in various stages of development in 25 states. These "Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models" encompass design, pre-testing and testing of state-specific models. While the federal Centers for Medicare & Medicaid Services (CMS) has defined 7 categories of innovation models, states have wide latitude as to where to focus their energies. These categories include:

1. Accountable Care
2. Bundled Payments for Care Improvements
3. Primary Care Transformation
4. Initiatives Focused on the Medicaid and CHIP Population
5. Initiatives Focused on the Medicare-Medicaid Enrollees
6. Initiatives to Speed the Adoption of Best Practices
7. Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models (Centers for Medicare & Medicaid Services 2014)



Connecticut's plan

IHC's home state, Connecticut, is one of 16 states receiving a federal Model Design grant. The $2.85M award was used to create a Healthcare Innovation Plan under an ambitious timetable in 2013. Connecticut's innovation plan highlights three key drivers of transformation of the state health system: **primary care transformation** to the Advanced Medical Home model, **community health improvement** and **consumer empowerment** (Connecticut Office of Health Reform & Innovation 2013). Eventually, Connecticut seeks to shift medical payments from the current fee-for-service model to value-based payment. Connecticut's plan to promote integrated care models cites **primary care practice transformation as a cornerstone for reform**. The innovation plan cites five critical elements:

1. whole-person-centered care
2. enhanced access
3. population health management
4. team-based coordinated care
5. evidence-informed clinical decision-making

PCMH reaching a tipping point

The concept and practice of patient-centered medical homes (PCMH) have been percolating in policy directives and practice innovations for several decades. We are now seeing a much higher profile for PCMH models: Among the 16 states that have recently developed innovation plans, Connecticut, Hawaii, Idaho, Maryland, Michigan, Ohio, Rhode Island, and Tennessee are committed to PCMH development; of the six states where reform plans are further developed and that received funding to test their innovation models, Arkansas, Maine, Massachusetts, and Minnesota feature PCMH initiatives. This recent activity is in addition to the growing number of smaller scale models in federally qualified health centers, HMOs, private practices and health systems.

PCMH is central to health reform efforts not because it is fashionable, but because there is documented evidence of its ability to improve adherence and outcomes and lower costs. PCMH can be particularly valuable in the provision of preventive services, which, in turn, can be highly cost-effective. The pathway from traditional medical practice to team-based PCMH is a wide and varied continuum.

There is now wide recognition that the fundamental ways that healthcare is organized and practiced in the U.S. needs to be revamped. The American Medical Association (AMA) acknowledges that the healthcare landscape will continue to change:

> *Governmental payers, the employer community and commercial health insurance companies are all pushing for more integrated healthcare delivery systems where physicians and hospitals are held accountable for the overall cost and quality of care. Regardless of the Medicare Accountable Care Organization (ACO) program's success, it is likely that all physicians will need to participate in systems requiring more communication, care coordination and quality measurement reporting.* (American Medical Association 2014).

The not-so-secret sauce for PCMH success

Shifting from traditional medical practice to PCMH may involve a host of adjustments: in attitudes, infrastructure, scheduling, information technology, information sharing and evaluation. It is consistently described as a "work in progress" by practitioners regardless of the stage of development. IHC's extensive training experience among leading organizations and a ***growing body of evidence support the primacy of communication for successful PCMH adoption and practice.*** Effective clinician-patient communication is critical; so, too, is communication within caregiving teams. To be truly patient-centered, care must take into account patients' values, wants, needs, and preferences, and the only way providers can learn those is to ask-and listen. Sharing information about patients with complex care needs demands thorough and efficient communication among caregivers, who may be in differing specialties and locations.

IHC training advances patient-centered care

There are a number of ways that IHC training--the "not-so-secret sauce" for PCMH success--advances patient-centered care:

→ ***Clinician-patient communication that is more empathic is more effective and saves time***. Rather than playing "Twenty Questions" with patients, clinicians who use communication skills such as reflective listening and open-ended questions reach a better and quicker understanding of the relevant medical and psychosocial issues. Such clinicians' diagnoses are more accurate and better accepted by patients.

→ ***Effective clinician-patient communication promotes stronger relationships***, which are critical to meaningful shared decision-making and associated with lower risks of malpractice claims.

→ With the tremendous and growing prevalence of chronic diseases in our population, clinicians are continually challenged to motivate their patients to make changes in their lifestyle choices and to adhere to long-term treatment regimens. ***Clinicians who learn and practice skills consistent with motivational interviewing find their patients improve and everyone experiences less frustration.***

→ Shared and informed decision-making, based on patients' values and wishes, leads to ***better adherence*** and can ***decrease unnecessary procedures***, thereby improving patients' satisfaction and lowering costs.

→ Care-giving teams that communicate effectively within teams are better able to coordinate care to meet patients' needs and communicate better with patients and families. ***Stronger teams are better equipped to solve problems, to everyone's benefit.***

→ Clinicians and other healthcare team members with strong communication skills are better poised to ***avoid burn-out***. This is important for the individual clinicians to have satisfying careers, for the organizations that employ clinicians so they can meet the demand for services, and for society at large that can avoid the costs, delays, and worse outcomes flowing from clinician shortages.

Notes

American Medical Association. Accountable Care Organizations. 2014. http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/accountable-care-organizations.page (accessed Jan 16, 2014).

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IHC's updated healthcare team communication offerings

IHC's recently-updated Team and Patient-Centered Communication for the Patient Medical Home (PCMH) curriculum has been expanded to encompass Gittell's Relational Coordination model, as well as IHC's E4 healthcare communication model. Together these inter-related models form the foundation and framework for skills and principles that are transferable to interactions with patients and with members of the medical home team. Healthcare organizations may opt for direct training workshops and/or for faculty training through IHC's PCMH train-the-trainer course. This skill-based program is open to all healthcare team members. It can be delivered as a traditional 1-day workshop or an expanded 1.5-day workshop plus simulation practice.

Learners have long cited simulated communication training exercises as the most valuable aspect of IHC training. For teams that seek enhanced training (but not necessarily faculty development), IHC is pleased to offer simulated skills practice sessions on the day following the traditional workshop. We are pleased to offer this uniquely effective training tool to all healthcare professionals involved in-or considering-PCMH model adoption.

> *Loved this! Great mix of theory and practice. Very effective exercises and debriefing highlighted purpose/learning. Pace was perfect-kept my attention and focus. Enhanced sense of importance of my role in teams and enhanced commitment to speaking up/contributing as a way to contribute to patient care. Increased my willingness to address team conflicts as a way of improving patient care. Bravo!* Feb. 2014 attendee

Contact us at info@healthcarecomm.org to learn about scheduling this workshop at your organization.

Upcoming courses are listed on the IHC website.

IHC is nationally accredited to provide continuing medical education and continuing nursing education by three major accreditation agencies (ACCME, AAFP, and ANCC). IHC takes responsibility for the content, quality and scientific integrity of all its CME/CE activities.

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