Ohio: Implementing a Patient and Family Advisory Council

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Again, we want to welcome you to today's session. We appreciate all the presenters' time and effort in preparing for— and sharing their valuable knowledge. Any statements regarding their technology, products, or vendors are expressions and opinions of the person speaking, and not an opinion of, nor endorsement by, the Center for Medicare and Medicaid Innovations, nor TMF Health Quality Institute, nor the host of the program. I would now like to pass control of the session over to the Sara Bolton. Sara?

Thank you, Marie. Yeah, thank you, Marie. And welcome, everyone, to our March CPC Action Period Call. Today's topic is implementing a Patient and Family Advisory Council. So we have a pretty packed agenda today, so let's dive right in.

Real quick— just an overview. We will be hearing first from Courtney Roman at the National Partnership for Women and Families. She is a content expert on this subject, and is actually working with one of our own practices— who we will also hear from later— Springfield Health Care Center.

Then we plan to hear from family practice— Dr. Wang's practice, as well as Springfield Center for Family Medicine, who have all implemented Patient and Family Advisory Councils in program year one. So without further ado, I will go ahead and pass the presentation over to Courtney.

Great, thank you, Sara.

You're welcome.

Good afternoon, everybody. Thanks so much for the opportunity to be here with you today. My name's Courtney Roman. And like Sara said, I'm from the National Partnership for Women and Families, which is a nonprofit consumer advocacy organization. And we are based in Washington, DC.

For those of you who may not be familiar with our organization, the National Partnership has been around for over 40 years. And it's dedicated to helping men and women meet the dual demands of work and family. For the last 20 years or so, we've focused significantly on the health care system, and ensuring that it meets the needs of women and families.

Our organization works on a variety of issues around improving the health care system. But my team in particular helps hospitals, ACOs, and primary care practices in many different areas of the country to partner with patients and families as a strategy for achieving their goals. And we have a really deep and rich history of working with patients, families, providers, and others in communities across the country.

More recently, though, my colleagues and I had the very good fortune of providing technical assistance to select CPC practices across the regions to support them in their efforts to partner and collaborate with patients and families. And despite the fact that we've been doing this type of work for over a decade now, I can tell you that we never get tired of hearing about groundbreaking work in the health care system that improves care for patients and families.

And we really know from experience that partnering with patients and families is more than just the right thing to do. It's a key strategy for helping practices to achieve their quality improvement goals. And that's why we've really been so grateful and excited to work with CPC practices since this initiative launched, because we feel this program really puts patients and families at the center of care, and encourages meaningful and collaborative partnerships. So I'm very much looking forward to hearing from the Ohio practices later in this presentation, and how you all have been able to achieve these partnerships.

So before I get started, really, in sharing with you both some ideas and opportunities for partnering with patients and families, and also what we've been seeing in some of the other regions, I wanted to stop and take a moment to thank all of you. In the midst of the stress and challenges that come along with starting something new, you can lose sight of the fact that you all are trailblazers and exemplars, so I wanted to be sure to virtually pat you all on the back. And I hope that you'll do the same for yourselves. You are truly pioneering work that will vastly improve the way care is delivered to patients and their families. And for that you should be commended and congratulated. So thank you.

So if you've heard any of my National Partnership colleagues speak at any point since we've been working on the CPC initiative, you've heard us say time and time again that partnering with patients and families is the key strategy for achieving CPC goals, including care coordination and patient experience with care.

And we really feel strongly that you cannot fully reach your quality improvement goals if you aren't meaningfully engaging and collaborating with patients and families.

Now I know that many of you have chosen to engage patients and families within your practices through one great tactic— by creating Patient Family Advisory Councils. And there are dozens of topics to discuss and projects to work on together with the patients and families who are members of your council. But regardless of the path that you've chosen for achieving Milestone 4, there are countless ways to partner with patients and families to help reach your goals.

And if you're still somewhat cautious about this work, or if you're sometimes unsure of the benefits, I'll share with you one key learning from our experience. And that is that patients and families can offer important insights and ideas that you may never have considered before, and can work with you to develop solutions to challenges within your practice that can save you time, energy, and precious resources.

So I know there's a lot on this screen. But you'll see here several examples that I've listed out, of partnering with patients and families. Either as advisors— but also more informally. Now you should know what I've included on this slide is really only a fraction of the partnership opportunities that exist. Your patients and families can be helpful with identifying challenges and solutions at every level of your practice. And I would encourage you— at whatever stage of the process you may be in engaging them— to think creatively and strategically about how you can collaborate together.

And I know there's sometimes the tendency to think of patient and family partnership as only being part of Milestone 4. And I think it's important to point out that partnering with patients and families actually can drive improvement across all of the CPC milestones. And it's a strategy for helping you to achieve all of those goals.

So you'll see on the screen that I've illustrated how many of these partnerships can map directly to your milestones. And the key takeaway here, I think, is that as you think about the challenges that you may be experiencing within these milestones, think of the challenges as actually opportunities for finding solutions in partnership and collaboration with your patients and families. Their insights and solutions will really help you work towards your goals across your organization.

So as I have this conversation with practices, my colleagues and I— we're sometimes told by staff that while these partnerships sound like a good idea, they're often unsure as to how to get started. So I'll give just a really quick example. And I'm going to use the patient portals for this example.

So if you're experiencing challenges around getting patients to use your portal, let’s just say— for an example. You could collaborate with patients and families on that topic. So either in an informal way, or you could bring it up to your Council— to work on identifying why that is— why folks aren't using it.

Do they find the portal useful? Does its functionality meet their needs? What types of information would be most beneficial to access to through the portal? How would they best learn to use it? Those are the types of things you can work with your patients and the families.

They can be helpful in identifying how well that patient portal is meeting their needs, and then come up with solutions with you for how to improve on it and how to best talk about it to other patients.

So now that we've looked at a couple of examples of partnership, and went into detail on one example, I'm going to turn now to describing some of the really wonderful examples of this work, and what it's been like for us to see it happening firsthand across the CPC regions.

So I'm going to start with the great state of Ohio. You're going to be hearing in just a few minutes from Debbie Cox, the office manager at Springfield Health Care Center. But I will just briefly say that they held their first council meeting in November, which I had the opportunity to be present for. And they were able to identify a well-suited, very enthusiastic group of patients and family members to work with them. And they really hit the ground running.

In two meetings, they've been able to work together to develop a list of priorities for the practice, and among other things, they're going to be working collaboratively to create care plan templates that work best for both patients and staff. But you'll hear more from Deb on that in just a few minutes.

So the second example I wanted to share is from Colorado. We are working with a multispecialty practice in a rural town in Colorado. And they are aiming to launch their council later this month. And they're in the midst of recruiting patients and families now, and will identify priorities with their help. But they're hoping to engage them around editing and re-drafting educational materials so that they better meet patients' needs. And also how to improve communication between patients and providers.

The third is New Jersey. We provided technical assistance to a practice in northern New Jersey, with two locations, and they launched a council in November. Their council consists of mostly older patients, which is reflective of the patient population at their practices. And so far, the providers and patients have worked together to decide how valuable their shared decision-making tools are, and they're thinking through challenges around scheduling and some other practice procedures.

And then finally is New York. We recently conducted a very unique site visit in New York. Because in this case, there are 10 practice sites in the system, which are all part of the CPC initiative. And we met with the group of 10 practice managers, and each site has successfully launched a council.

And the interesting point to note that I wanted to raise here about New York is that while they had done patient experience surveys in the past, and while they were receiving very high response rates, they felt the information the survey was providing was not actionable enough. So because of that, they worked to launch councils, and are already experiencing much more meaningful partnerships with their patients, and seeing the great value that can come from working in collaboration.

And in terms of priorities, the 10 sites all differ, but many are planning to engage in practice walkabouts, where patients and families walk through the entire practice, from check in to check out, and they look for opportunities for improvement and develop solutions in partnership.

So regardless of the region, or the specific challenges that you may be facing in your practice, patients and families can really help you to think about them strategically. And then develop, implement, and evaluate solutions.

So before turning things over to our other speakers, I wanted to leave you with a few best practices that we've identified while working with patients and families and staff on launching Patient Family Advisory Councils.

The first is to start before you're ready, but plan for success. And this work is kind of like having a baby or buying a house. There's really no perfect time. And if you keep waiting until you think you're ready, you're going to miss out on lots of opportunities.

But you do want to plan for success, by making sure you have a person within your practice who will lead and be accountable for your Patient Family Advisory Council. And ideally, this person would understand the value of working with patients and families, and have the interpersonal skills to facilitate collaboration among patients, families, clinicians, and staff.

And second, you want to start to encourage everyone in your practice to move away from doing things to patients or for patients. But instead, doing with them. So this can be a real shift in how you provide care and do your work. But I think you'll find in the end it's the best way. And truly, mutually collaborative partnerships aren't doing to or for, they're really about doing with.

Third, spending time on recruitment for your council is a worthwhile investment. We've heard from some practices that finding the right mix of patients and families meant they were in recruitment mode for a little while, and that's OK. Even if it means you don't launch your council as quickly as planned, it's worth taking the time to find patient and family members who are excited to be working with you, and will be solution-oriented, strategic, and thoughtful in this role.

And finally, I would like to think long-term about this work. I know that you all are exhausted. You've started something new. You're identifying and recruiting patients and families. You're planning agendas and meetings. And all on top of your regular duties of providing care. That is not an easy thing to do. But I want you to know, though, that when you launch your council, and everyone begins to feel more comfortable in their role, that you can begin to look to a shared ownership of the group.

So for example, your patient and family advisors can eventually begin to work with you to draft shared agendas. They can take on more of that role. They can help staff with recruitment. They can also be part of initial discussions that staff have when new potential advisors are being interviewed. And they can also be very helpful in telling— sharing with the community what they're working on.

So I wanted to also mention before wrapping up that if you're still having trouble envisioning how these partnerships could happen, or you're just wondering still how to get started, we've created a detailed step-by-step guide on how to create, launch, and sustain a council that also includes many more best practices. And it is available on the learning collaborative website, if you'd like to download it and take a look.

So just as a final word, I wanted you to know that in the spring— if it ever comes— the National Partnership could have the capacity to provide technical assistance to a few more practices in your region. So if you're interested, potentially, in getting support from us in helping to launch a council or to keep one going, I ask that you reach out to your CPC regional faculty. And then they'll contact us about that opportunity.

So thanks again for the chance to speak with you all today. And I know we are moving next to any questions.

Great. Thank you so much, Courtney. And I will say that's a very exciting offer that the National Partnership is putting forth to our region. And I would really highly recommend those of you who are planning to start your council this year— if you have interest in that type of technical assistance, please reach out. I think we'll hear from Debbie Cox next. But I think that's a very valuable offer.

So thank you for that overview. I think it really does tee up the concept nicely, and really shines a light on how your Patient and Family Advisory Council really does cut across— and should cut across— all milestones. Even though it's squarely kind of rooted in Milestone 4, it really can help drive improvement across all your work.

So I think it's a really exciting opportunity. We only had a few practices that chose to do it in Year One. And we're going to hear from four of them now. But I want to do a quick informal poll and see how many of you are planning to incorporate councils into your work in Year Two.

So as you know, Milestone 4 has three options. Option A is to move to monthly surveys. And then option B would be to implement Patient and Family Advisory Councils with quarterly surveys, and then option C would be to do quarterly council meetings.

So if you can check— click on the check mark that is underneath your name, and either select yes if you plan to do either option B or C, or no if you plan to do option A. I'm just curious to see how many of our practices plan to do this. So again, click on the check mark, and the first option would be yes, second option would be no. And we'll just give you a few seconds to see how we're shaping up.

OK. It looks like we have a large chunk of practices that are planning to implement Patient and Family Advisory Councils. So that's exciting. I'm glad to see that, Let's go ahead and move on to our practice sharing. This is the exciting portion of our event.

So first we'll hear from Debbie Cox at Springfield Health Care Center. Debbie is the practice that is currently receiving technical assistance from Courtney. And I'm sure she will share how beneficial that has been. So without further ado, Deb, I will pass the ball to you.

Thank you so much. Yes, we have initiated a partnership with Courtney's group, and can say that it was very valuable to us. They really have a great document that Courtney was referencing. It really does step you through— very logically— how to get started, and has a lot of good information in it. So I would encourage folks to take advantage of that.

And to also take advantage of the technical assistance, if that's something that you would be interested in. We have found it to be incredibly helpful.

So as far as our experience is concerned, the staff involved in our project consists of our physicians, our care coordinator, our nursing staff, and myself. Our physicians rotate meetings. They take turns. That works well. The patients then get to meet and get familiar with all of the physicians, and the physicians don't feel that burden to have to have one of them always be responsible.

Our care coordinator comes to every meeting, just because she is the person that's kind of the clinical face of our practice in many ways. And so she's always there. And then the nursing staff also rotates.

And surprisingly, they have found it to be really valuable, and look forward to the meetings. It was a bit of a surprise. We were concerned that folks would not really want to participate. But I think once they got there and kind of developed some familiarity with it, they actually found it to be really something they enjoyed doing.

And then, of course, I'm at all of the meetings as well.

Recruitment was something that we really didn't have any idea how to go about. And so this was one of the areas that we got the most assistance with, by following the guidelines in the document that Courtney referenced.

We chose to use the process where our physicians actually recommended the participants. We asked each of our three physicians to give us a list of about five— either patients or family members— that thought would it be good participants. They're familiar with them. They kind of know their needs. They know how they interact with the practice today. And we found that to be actually very insightful.

We had no issue with recruiting people. We started with five from each physician, and we have no problem getting at least three representatives for each of the physicians.

We— at the first meeting, or prior to the first meeting— sent out the patient and practice compact template, which was provided by the National Partnership. It's a really worthwhile document that describes the patient and family members' roles and responsibilities, and the practice's roles and responsibilities. It gives you a framework to work in so that folks understand what the council is and is not. The things that we will do and how we'll conduct meetings and so forth. And then we also used the confidentiality agreement template that was provided by the council as well.

Our first meeting was primarily— other than introductory, we did conduct a roundtable at that initial meeting, and just ask family members to share one really positive thing that they felt they wanted to share about a practice experience. And at least one item that they felt we could improve on, or that they had concerns about, or that they thought would be helpful.

We gathered all of that information from that meeting. And then we included three key topics that the practice really wanted— and had identified ahead of time that we wanted the council to help us with. And those were our care plans, our shared decision-making, and communication in general. We then, at the second meeting, chose our top five topics from this master list.

Keeping in mind that a lot of the items that were brought up in that initial meeting were small things— were things that were just a matter of somebody paying attention to and addressing— so we had a lot of items that we were able to come back to that a second meeting and say, here's what we did about your concern.

And so there's a lot of that we have found happens at each of the meetings. In addition to major topics that you may want to work on, you're going to get a lot of feedback about little things, or about things that don't take as long to resolve, or as much time or money to resolve those types of things. So it is helpful in that way, too. There's a lot of good information that you get about just routine things.

Our council is currently meeting every four to six weeks. That was the patient and family advisors' request. They have been very enthusiastic and very excited about the things we're working on. And so they really want to meet more often than our planned time of meeting quarterly. Eventually, we may get to just meeting quarterly. But with the things that we're trying to do right now, they were happy to try to meet more often.

We've had perfect attendance. We have not determined at this point if we're going to offer some type of compensation down the road. It hasn't seemed necessary yet. And so we're leaving that to be determined.

We do offer refreshments at the meeting. And our group decided that their meetings— we'd meet about 4 o'clock in the afternoon. And that works for our group.

Our agendas are driven by the meeting activities, and the decisions and timelines that we're working on. We haven't really gotten too far into developing action plans for yet, because we're just early in the process. But again, there are some templates out there on the collaboration site that you can use for action plans. You may already have them in your practice that you've used for other things. And so that's in development for us at this point.

Lessons learned— it's not as scary as we thought it would be. I will tell you that there were a lot of butterflies and a lot of stress. [INAUDIBLE] But it went very smoothly. The group actually kind of took off. And we're very participatory. And I don't know if we just got lucky that our physicians did such a great job of selecting candidates, or that's a normal response. But we have had no issue keeping conversation going and keeping ideas flowing . If anything, it's a little bit of a challenge for us occasionally to keep the meeting on track. Because the group's very excited to be there, to be participating, and they have lots of opinions and ideas that they want to share.

And I think just from the staff perspective, we had no idea how enthused and how invested our patients and their family members would be to be given this opportunity to partner with us. And so, as I said, I think that the staff's excited to go to the meetings. We have found it to be something that's really grounding us in why we're here. And that's something I don't think we really thought about or anticipated when we got started.

As far as next steps are concerned, we're working with the council on communication overall, how to share information with patients, how they like to receive that, how they want to see education given. And then, more importantly, how we can take what we're doing with this group and spread it out to the overall practice— sharing ideas and suggestions. So we're working on that as we move forward, as well.

The care plans are something that's very near and dear to my particular group. And we are going to be using that as one of our first focuses. Are there any questions?

Great. Thank you so much, Debbie. That was a really helpful overview of what you're doing. And I love the idea of using the council to vet your care plans and work on how to improve those. I think that's so crucial with getting by-in from patients, on actually feeling like they're a part of the care plan, and making it really focused on self-management and not just clinical goals. So I think that's such an excellent place to start. And I'm glad to see that you're doing that.

I'm just curious— and please, if any of our participants have questions, go ahead and type those into the Q&A, or feel free to raise your hand and we can unmute the line as well.

But I had a quick question. Did you give the participants any sort of time frame for participation? For instance, are they planning to serve for one year, or for the length of the project, or did you not get that detailed quite yet?

Oh, it looks like we lost Deb.

Oh no.

OK, well, hopefully she can call back in, in case there are any questions. I don't see that any have come through yet. So we'll see if we can get Debbie to call back in. But in the meantime, why don't we go ahead and move forward? We did get one question from Jan. Jan, we'll wait until Debbie's back on the line. And we'll go ahead and move on to our next speaker, and then— and address your question later if that's OK.

I'm back.

Oh, hi! That was quick.

Sorry— I heard your question, got ready to open my mouth, and my phone was gone. I apologize.

Oh no. OK. That's all right. Well, thanks for calling back in. Yeah, so go ahead.

So I lost my train of thought. I apologize.

Oh, that's OK. Just wondering if there was time— if you set forth time frames for the participants in the council. So did they plan to serve for a year?

Actually, we did not at this point. I think that what we discussed amongst the council— and I think what Courtney and the Partnership recommend— is that you maybe do a rolling kind of a process. So that you don't lose everybody at the same time and have to kind of start over.

So I think we're going to do that sort of a process, but we haven't really decided whether it'll be— keep some of these folks for 12 months, and keep a few a little longer than that, and start rolling it over that way. Have not made a decision yet.

OK. That makes sense. We did have a question come through from Jan, that was— was there any attempt to diversify the group— by age, gender, economic status, et cetera?

Yes. Each of the physicians was asked to think of their patient population, and give us— with five patient opportunities for each physician, it allowed them to pick a diverse group of patients as far as age and ethnicity and socioeconomic situations and all of that. And we feel like we came out with a really, really well diverse group of patients that really is representative of the practice.

We do have a more senior population. And so it is more senior than maybe other groups would be. But it is representative of our particular practice.

OK, great. Thank you so much. Well, I don't think any other questions right now. But I think they'll continue to funnel in as we hear from other participants. So thank you once again, Debbie. And let's go ahead and move on to Family Practice Associates of southwest Ohio. And we're going to hear from Debra Southard. So, Debra?

Good morning, everybody. So, to start out— when we decided we were going to do— Family Advisory Council, we thought maybe we'd do the surveys. But then we equated it to— it's kind of like going to a long-time family reunion— you didn't know what you were going to get. But even despite that, we decided we were going to do the council, because that was the apprehension.

But we just thought we were going to get better data. Because you can have a two-way communication. They can give input. You can ask questions. And when you did a survey, you couldn't do that. And we just thought it would really give us the ability to implement change, to measure along the way. And it's been a really positive experience for us. But we're glad we chose it.

But when we were doing this, we picked one physician. I sat on the group. We had our clinical team lead that's over all our medical assistants and our care coordinators. And then Sandy, who is our administrative assistant for CPCi, was pretty much the leader. She has done all the paperwork, all the legwork, all the phone calls, all the emails to all of these patients. So she's been a key component for us.

But when we went into the recruitment, we kind of took a different strategy. Not only do we want the normal— different ethnicity and age, we also wanted different education levels. We wanted people that had children, people that had elderly they cared for. We also wanted to balance out who could get online and do portals, the technical ones.

And then we even moved it into risk stratification. We didn't want just all healthy people on our board. We also wanted— we've got one that's 80 years old. And he has high complexity, but he gives some of our best input.

So we wanted just that whole diversity. And then we asked our board, when we initially were selecting them— we picked five patients from each physician— we wanted them to give a two-year commitment. Because we felt, since we meet quarterly, we would want them over a two-year period to be the same group of people. Measuring where we started to where we could get in a two-year period.

So in the whole process of recruiting, we basically sent a letter saying we're going to create this council— or this board— And this is what we're going to do. And it was about a page and a half long. And then we said, we would follow up with a phone call, which Sandy did the phone calls. And when she called them, not only did she talk about what an advisory panel did, in a board, but she inspired them of why their input was so important.

So we didn't have a single person turn us down when we did our initial invitations. They were all excited to come in and see what we are actually doing, and what it would mean to participate.

So then once they said yes, we'll do this, what we did is we thanked them for their commitment. And then we went into the next stage with them, which is where we were going to focus. We had a long discussion about this, but we decided we weren't going to focus on just one thing, like diabetes, or how we got patients in. We took the whole spectrum of the practice.

And then once we did this, what we created was a very long survey that we sent to our advisory board members a month prior. We gave them instructions of how to complete it and what we were looking for, a self-addressed envelope, and when the survey needed to be back. And every single one of our board members gave us more than what we expected on the survey, and they all had them back on time.

Then what we did is we took the survey from our patients before our first meeting, and that helped us create our first agenda. One, we were shocked with the answers we got, because we thought we were hitting everything on all cylinders, and learned that there were a lot of areas we did need to improve. Which, I think, kind of motivated us for the first meeting.

And then in the first meeting, we went around and talked about the goal of our group. Everybody introduced themselves. We went through the survey. We went through the vision for our whole group. We told them how often we were going to meet. And then we just had 2 and 1/2 hours of this whole camaraderie around this agenda— about how we could better serve our patients through this board.

And so we have board members— our youngest board member is 20. Our oldest board member is 80. And we have all ages in between. And we just thought we had a really good group.

The other thing we did in our first meeting that we thought was really important is we had the patient compact, that kind of explained to them what would we be doing and the objectives. Because I think the fear of a lot of patients is we're going to talk about their health. So we laid that out right in the first meeting, that we wouldn't to be talking about their diagnosis or their conditions. We would just be talking about their perspectives as a patient in our practice.

The other thing we also did look at, too, is how long someone had been in our practice. So we wanted some people that were newer, and some people that had the longevity within our practice when we had that first meeting.

So every time we have a meeting, now— we have ours quarterly— we base it off the previous meeting. We start out our meetings by talking about what we did, or implemented, based on input from our council. And I think when they see the complexity it takes just to schedule an appointment, or to triage, or to take you to a specialist, they were kind of excited to see all the things that we put in place. They were shocked by the workflows we do. But with our group— we had six to eight the first year. We've added another one this year. So think we're a solid nine or ten for every meeting. And those are just the patients. And then we've also got our team.

But our people don't want compensated. We even asked them that, if they felt they needed to be compensated. And they said no. We do buy them a really nice meal on the evenings that we do meet. But other than that, they were just so excited to help us make a difference in our practice, which I think was an inspirational part for us as well.

Along the way, some of the lessons that we've learned is that you have to set your objectives in advance. We set the meeting agenda— or if there's any data that's going to be reviewed— we send that out to our board meeting several weeks in advance to give them time to review it, and then bring really good questions to our team.

We do things like put words up on the wall on certain topics, and they'll take little Post-it notes and they'll write what they feel about those. And those are some of our takeaways after our meetings. But we just find that your patients are going to be really honest. And what you need to tell them is you want them to be. That there's nothing they're going to say that's going to offend you. Because their input makes you better.

And when you get this data, and you really listen to your advisory boards, and you start putting workflows in place to better that, you'll just be amazed the outcomes you get. So we share everything with our board. They know what patient-centered medical home is. They know what CPCi is. They know the obstacles we've had to overcome. And I think that they respect us and we respect them for that factor.

But when we're thinking at the end of the lessons learned, we want to see their viewpoint. It's the greatest asset that we have. We've made a tremendous amount of change in year one based off their feedback. And we do believe it's influenced our outcomes on a very high level. And we do have people on the board that don't have a computer. They don't use a portal. They don't ever want to use it to interact with their physician. So it made us think outside of the box of— how do we hit that percentage of population that don't want technology?

And I think at the end of Year 1, it came down to— it was the best decision we made, going with our Patient Advisory Council. We want to expand it. We want to do more with it. But it's overall been a very positive experience.

So some of the things we're working on right now is we're trying to incorporate into a newsletter what we do with our board. Let our patients know who our board members are. We want to put it on our website. And we just want to keep growing it.

But if you took our whole team together with our board, I think the one lesson learned for us is— when you get really good, honest patient input, it's going to lead you down a path allowing your clinical teams to be successful at a much higher level. Because in the end, it's all about the patient being our number one priority. And I think what it's done for us is it's totally empowered us to be better at what we do.

Great. Thank you so much, Deb. While we give a moment for people to type in their questions in the Q&A box, or raise their hand, I'll ask— I would imagine that being able to show the council that you are, in fact, incorporating their feedback into action would be really important for buy-in and continued work with them. Have you been able to have any early wins? Or show them— look what we did with your feedback— we've really implemented this new process, or made this change?

I'll tell you a real simple one. The first board member says, why do you nag me about appointments? I don't understand an appointment. So our council agreed that we were never going to call it an appointment again. It was going to be the next visit in your care plan. So everything we did— our literature— we don't have appointment cards now, you have care plan cards now. But that one little change— and then when that board member saw that we made that change, it lit them up, and the whole board was like, we never thought of it that way.

So it's just putting yourself in the brain of the patient. And giving them something that simple was a big change. We showed them our progress with diabetic patients in. And they were shocked that we worked that hard to change outcomes. So it's just really important to be honest with them that every piece of information they give you— you're taking it, and you're doing something with it.

Great. Thanks. Looks like we did get a question come through from Amy at PriMed. What were some of the points that the administrative assistant told the patients? I think she means on the call that they found inspirational. What were they—

When they were recruiting them?

Yeah, I think that's what she's referring to.

OK. Some of the first key things we talked to them about is that we were a patient-driven practice, and the only way we could have better outcomes for our entire patient population was to have really good patients that would give us really good input. So the first thing we did is we complimented them for being a really good patient. And for patients who had been our practice for a long time, then we slid over with the— you've got such longevity with our practice. So we know you must already have a really good relationship. We want to know how to make that relationship better. And you're the key to that for us.

So we just would go through little tidbits. I'll be happy to send you— Sara, if you want to send it out— what our initial intakes were for these patients, and what our surveys were. Because I think just a good guide.

Yeah, absolutely. I would love to do that. And I think that's a perfect kind of thing that you can share on the collaboration site from Milestone 8.

OK, I can do that. OK.

But yeah, I would be happy to send that out. We can include that in our next newsletter. Thank you. That would be great.

OK.

OK, well, in the interest of time, let's keep moving. We've got two more practices teed up. Thank you so much, Debra. Next, we will hear from Dr. Wang's practice. We have Allison Boone and Karen Werline. So I will go ahead and pass it off to you, Allison.

Thank you. It's just Allison today. Karen's unable to make it. But I am the Care Coordinator here at Dr.Wang's office. I've been here for about nine months. And we are down here in Terrace Park, Ohio. And we did the council instead of the surveys because we wanted to have the one-on-one time with the patients.

[INAUDIBLE] the staffing and staff involvement, we are all involved with it. The whole office, I mean. The office manager was the principal person involved in the recruiting. She put together the list and sent out the paperwork and the letters and everything like that. But we tried to get a council with patients from a variety of demographics, and ages, and ethnic groups for the council.

As far as the strategies go, we all participated in providing a list of patients that we thought would be good for the council. The doctor did. And so did the staff members. If the patient was in the office before the council, we did try to get a one-on-one with them. And then if they would be interested in participating in the council. And then we did send out a note as well. And then we were sure to follow up with a phone call if they did not RSVP to us when it was getting close to the council time. And then we were, of course, sure to involve any kind of brief description of what the council was about.

Focus areas for the council for us was just really basic at first. Of course, we wanted to introduce what the community care was all about and what, as the care provider I was doing. But we wanted to just— as a practice— find out how we were doing. So [INAUDIBLE] talk about the appointment availability, how they're doing with their phone system, and how they feel they our billing. And wait time in the office, and just basic things— about the doctor, and check in and check out. Sorry. Just real basic things at first. And getting just some [INAUDIBLE] back from them and see how they're feeling about the practice. And then their time at the office.

For the meeting itself, we have them on Wednesdays at [INAUDIBLE] at Panera. And that's their compensation is just Panera lunch. We do not do any other kind of compensation for them. [INAUDIBLE] their role as the council, and why [INAUDIBLE] of why we're doing the meetings. And we always have an agenda beforehand. And we try and all be there for the meetings. And we [INAUDIBLE] a lot of questions and answers time for the patients.

We really get a lot of feedback from them. Let them know that there are very important. And try to make sure that they know that they can be very honest with us. And otherwise they just want to sit there and listen and not provide a lot of feedback. But we really want to give us the feedback, so that we can try to improve the practice in any way that we can.

Our action plan after the council— we haven't had a lot of time to do much, but we just wanted to make sure that we're renewing the importance of the communication with the patients. One of the things that was brought up in the action was— in one of the meetings, I'm sorry— that the patients [INAUDIBLE] informed if we're running really behind. So we try to do that when we're writing the schedule. So we're really trying to implement that.

And then we're trying to implement the patient portal sometime this year. And then we're [INAUDIBLE] the phone system to make sure that the patients understand that when they're here in the office as well.

But [INAUDIBLE] we've learned was it was very rewarding. It was very rewarding for the patients. It was very rewarding for the staff. Don't be afraid. The patients really loved it. They loved being involved. They loved being heard. And I think that they really thought it was a great experience. [INAUDIBLE] And they felt very honored to be there. It was— it wasn't as [INAUDIBLE].

So our next steps for [INAUDIBLE] will be to continue to do them. And to continue to [INAUDIBLE] that their opinions are important. And just continue our care coordination standing to make it better. And we're going to continue to do the advisory councils, and just continue to improve any way we can here in the office. And our questions are next.

Great. Thank you so much, Allison. We'll give a few moments for questions if anybody has questions for Allison.

Kelly?

Yeah?

Kelly, Dr. Wang walked in. He wanted to say something.

Oh, perfect.

Yeah, just saying for the family council, it's a great recruiting tool— compared to sending people anonymous surveys, and check off boxes, and fill these things out. Patients are really excited. They want to talk to us and meet with us. And if we involve them, they're really excited. It's really great for our [INAUDIBLE] and recruiting as well, too. Thanks.

Great. Thank you so much, Dr. Wang. We really appreciate that feedback. And I love to see how positive these have been for all of the practices who did them in Year 1, and I really hope that inspires some of you to choose this option for Year 2, as well.

So we're getting a little short on time. So I'm going to move forward to Springfield Center for Family Medicine. And we're going to hear from Cindy Brewer. But if you do have questions for Allison or Dr. Wang, please feel free to type those into the Q&A, and we can hit those at the end as well. So Cindy, I will go ahead and pass it over to you.

Hi, this is actually Tina Wildermuth. Cindy Brewer was called away from the office this morning. So I'm going to be filling in for her.

Hi, Tina.

I am the Patient Family Coordinator. And I also have our Care Managers here with me, Jenny and Lacey.

So as far as staffing, what we did is we came up with a phone script for recruiting. We went around and spoke with all of our physicians. We spoke with all the staff members and clinical— both clinical and office staff— and asked them for their opinions on what kind of patients would be good for this type of setting. And we got a lot of names, and we basically sat down and did all of the calling on that.

We looked at things— we did run some reports to also, then, look at those patients, and get a good group of— we wanted to try and determine a group of age and race— their ethnicity— conditions— physical conditions they were dealing with. And then we just broke it down and started looking for age groups. Parents that have small children in the practice. Maybe the parent wasn't a patient.

We ended up getting six members, and they're broken down between our six doctors. And our staff— we really like. They're very informative. They have a lot of really good ideas. So it's worked good on that.

As far as the office staff, we have one physician who did it for the first three meetings we had. And now we have a new physician for this year. We also had one member from each area of our office. So we have a person from billing, we have a person from our clinical, we had a person from our front office, and then we also have the care managers also come and attend.

And again, this year, we switched and got new staff members. The only people who are still there that were the last time is myself and Cindy, the Office Manager, and our Care Managers.

So our focus area— how did we determine— For our very first meeting, we did hand out the surveys. We are doing both options B and C. We are doing quarterly surveys, as well as having the meetings with the council. And for our first meeting, we did do a survey. And we went through— took a lot of time to break that down and figure out what areas we needed to focus on.

And we also were shocked at some of the results. We felt like we were doing a fairly good job in areas, but we did have quite a few complaints in a few of our areas. The largest one was being the phone system. And the runner-up to that was the patients' wait time to see the physicians.

So that's how we determined what we were going to discuss. And since then, we also continue to do the surveys, and we kind of feed off of that. But we also just ask our patients to give us ideas on what they feel needs to be addressed— what they would like to be a focus area to speak on.

And I know that for our next meeting that we'll be having next quarter, it will be driven towards the patient portal. We have started using that a lot here lately. We are signing up every patient as they come in. And then, of course, they have to do their part on their end. We have several— quite a good group of patients who are doing that, but not as many as we would like. So we would like to discuss with the council ideas on how we could get patients to be more involved in that.

So the council detailed— we pretty went through that, and who's attending. Our action plan— We did do some PDSAs on trying to figure out how to make some improvements. And we did make improvements with our phone system, especially our appointment line. We went from only being able to leave messages to having a live operator taking calls. That has been a big improvement in our practice, which the patients are definitely appreciating.

As far as the wait time, we started having our staff inform patients ahead of time— if their physician was running behind, about how long, and giving them the option to either reschedule, or we offer a light snack, especially if it's near lunch time.

What kind of lessons have we learned? So basically, when we first started out, we really didn't know exactly what we were doing. And we did follow the CMS and Health Collaborative guidelines to get started. We really do strongly believe that doing the surveys and the council is a good way to go. It does— we want the council members' feedback, but we also want the feedback from all of our patients. Because the council is only a small group. And we really do want to know how all of our patients are feeling about our practice. Because becoming a patient-centered practice is what we really want to go for here.

About how we're going to integrate more patients into the PFAC— we have an office bulletin board that we just set up not too long ago. And the care managers actually control that for us. And we do have a lot of information on there. But one of the things we have is an announcement about the Patient Family Council.

We also have hour meetings at the lunch hour, and we provide them in our waiting room. We are providing lunch. And we are providing them an honorarium, as well, to attend the meetings. They haven't asked for it. It's just something that we wanted to do to show them our appreciation for all that they're doing to help us. And we do have a lot of patients during that hour who are still coming in and out to see their physicians, or picking up or dropping something off. And they are asking about what's going on. It is a time for us to be able to share with them exactly what we're doing. Are there any questions?

Great. Thank you so much, Tina. And I will say, please do chat in your questions into the Q&A box if you have any for any of our speakers today. Or if you think of some later, please feel free to email those to me, Kelly, Barb— any of us on the team— and we can get you responses to those.

I really like how you're using your surveys, and then leveraging that information to really dig into it with your Patient and Family Advisory Council. I think that's a really great approach. It lets you really get at the reason behind the way maybe people are responding the way that they are to the survey, and lets you really get at how you can make those improvements. So I think that's a really great approach for others to think about.

So let's see. I have not seen any other questions come through. But we still have a few more minutes. So why don't we go— and I can cover some important dates real quick before we close. Next week, we have our Systems Meeting on Monday. There'll be a webinar on Tuesday— that's a national webinar covering the integration of behavioral health. That is set to be a really good topic, I think.

Then we will convene our independent practices on Thursday. Later that day, there will be another national webinar that will review attribution and how that's done at the— from CMS's perspective. Just as a reminder. Then on the 25th, there will be another webinar— a national webinar on another option for Milestone 2 around self-management.

And then most importantly, our learning session coming up on March 28. So as a reminder, that's a mandatory, face-to-face meeting for all 75 of our practices. We have a full day— 8:00 to 3:00 PM— chock full of goodness. So if you haven't registered yet, please do so. We do have somewhat limited space. But we want to ensure that we have everyone marked down who plans to attend to make sure we have enough food and beverages for all of you. So look for that invitation. It came from Kelly Aardema. So search through your inbox and find that. If you have not yet registered, please do so.

And this is Kelly. I have another comment on the learning session. I am putting together vendors or community partners for our community resource fair during the learning session. If there's any organizations that you have been working with, or that you would like to work with, or you think would be beneficial to the practices, please feel free to send me your ideas. We're always looking to improve our value. And I would really like to hear from you.

Great. So thank you once again to all of our speakers today— Courtney and all of our practices who were willing to share. This is very helpful, I think, and it really outlined that there's no one perfect, right way to do this— but there are lots of different approaches and ways that you can use these councils to really affect and drive improvement for all of your CPC work.

So thanks again, and we are at the hour. So have a nice afternoon.

This is Marie, and we want to thank you for coming to the presentation today. We would like to ask you to complete the survey. If you click on the file, "Leave Event," you should see a survey pop up. Thank you so much for attending.