



Stories from the Field: Implementing Principles of Person-Centered Care

In September 2021, the Health Care Transformation Task Force released five principles on delivering Person-Centered Care as Cornerstone of Value-Based Payment ("Principles"). These principles are designed to help health care organizations assess their current practices and develop strategies to operationalize effective, person-centered care programs and policies and advance health equity.

The Task Force now releases an accompanying resource, which identifies specific operational actions health care organizations took in their pursuit of patient-centered care and provides examples of best practices and strategies being deployed to advance each principle. The best practices provided below are just a small set of examples and are by no means exhaustive of the patient-centered care innovation occurring. As other best practices are identified, they will be added to the resource and refinements will be made to the operational actions as appropriate.

Putting the Principles into Action

Organizations across the country are already employing best practices to achieve the five principles. The Venn Diagram below provides an overview of the strategies used to achieve each principle, with the following pages digging deeper into each case study. The strategies do not just apply to one principle, many overlap between the five.





Operational Action Checklist

To implement their respective patient-centered care and health equity strategies, organizations are executing against the operational actions listed below. These are critical to successfully addressing the scope and objectives of the principles.

Establish the Team, Roles, Accountability, and Feasible Timeline

- ☐ Identify departments, staff, and funding streams that will be instrumental to the effort, including programmatic (e.g. community engagement, communications), human resources, information technology, clinical, and legal/compliance/regulatory departments as appropriate.
- ☐ Coordinate across departments to ensure new efforts are leveraging existing practices and capacities, particularly in data collection.
- ☐ Present a return-on-investment (ROI) plan to leadership to gain buy-in to investing in effective data sharing. Recognize that establishing these strategies for data collection and analysis requires a long-term horizon for developing, testing, demonstrating, revising, training, and succeeding.
- ☐ Acknowledge the importance of collaborating and coordinating across departments to develop successful quality improvement procedures.

Standardize Demographic Data Collection, Stratification, and Analysis Practices

- ☐ Create or use existing tools to collect demographic data (Race, Ethnicity, Language, Sexual Orientation and Gender Identity, Disability Status, Veteran Status, and others) information from patients.
 - Train staff on how to collect this information in a manner that is respectful, culturally congruent, and builds trust between the patient and provider in both the purpose for collection and the ways collected data will be used.
 - Work to ensure that the data collection tool integrates with existing electronic health record (EHR) technology.
- ☐ Establish data governance policies that define the parameters for how and by whom a patient's data will be used.

Data governance policies are a critical component to safeguarding patient data. These policies are important for organizations to know how to safely use patient data, and for patients to understand how their data will be used. Patients, especially individuals from racial or ethnic minority communities, are more likely to withhold personal health information if they have confidentiality concernsⁱ.

Data governance policies should include guidelines for sharing data with outside organizations (including community-based organizations who may use different EHR systems and have different data guidelines), use in Artificial Intelligence and third-party products, and more. The policies should be in compliance with state and federal privacy laws, and should include the consequences of improper or unauthorized access to and use of the data.

- ☐ Create standards for both social determinants of health (SDOH) screening, and for next steps after a patient screens positive for needing additional supports.
- ☐ Create closed-loop referral systems to refer patients out to community-based organizations (CBO) that can help address the social needs of the patient.

Incorporate Patient Voices into Policies and Programs

- ☐ Patients know themselves best and know what is important to them. Engage them to identify these priorities, (e.g. facilitate focus groups) in ways that are accessible (language, location, time of day) to the greatest number of patients.
- ☐ Compensate patients for their time and expertise during these engagements.
- ☐ Ensure that patients are represented at all levels of decision making, from clinical level to governing boards.

Outreach and Engagement with Community-Based Organizations

- ☐ Perform consistent, meaningful outreach within the communities served to ensure that the connection and contact information with community-based organizations (CBOs) is up-to-date.
- ☐ Create and/or leverage existing opportunities to partner with CBOs through funding and through shared governance and decision-making.
- ☐ Use closed-loop referral systems to connect patients with needed social services.



Principle One

Effective value-based health care delivery systems elevate person-centered care, including individuals and care givers as active partners in all aspects of their health care decisions and continuously build consensus perspectives of individuals - including those typically underserved - into health care organization level product design and care delivery operations.

A central tenet of person-centered care is “nothing about us without us.” Traditionally health care has not focused on the patient or consumer perspective. While the concept of engaging the patient is not a new one, creating a process in which consumer input is translated into health care organization-level changes largely remains an unmet opportunity. The following practices exemplify institutions that are focused on creating a 360-degree feedback loop.

Engage the Community

- **Engage with Focus Groups:** Sun River Health – a Federally Qualified Health Center (FQHC) with over 40 health centers in New York state – hosts patient focus groups to receive feedback from patients on their experience of care. Sun River asks three questions of the groups: (1) what do you like about the services being received; (2) what do you not like; and (3) what would you like to see done differently? The feedback is used to identify areas of success and areas of improvement, and is shared with site leaders across the state to help monitor quality control. Moving forward, Sun River would like to expand their questions to the focus group and ask about how they can help to achieve specific health goals.

With the world transitioning to virtual meetings during the COVID-19 pandemic, Sun River saw an uptick in attendance to their focus groups. Noting the difficulty of picking up body language on virtual calls, Sun River Health invested in a trained group of facilitators to lead the calls. Further, after querying the Spanish speaking population served by the focus groups, Sun River Health chose to offer the calls solely in Spanish to meet the patients’ needs.



- **Establish Community Advisory Committees:** Sun River Health has regional community advisory committees made up of ex-board members, patients, community members, and community advocates. Sun River shares strategic initiatives related to the operations of the health center to solicit feedback from the committee members. Sun River also discusses matters affecting the community to see how, as a community partner, it can work collaboratively with others to influence positive outcomes.

The Community Engagement department at Sun River Health oversees both the community advisory committees and patient focus groups mentioned above. Within this department, Sun River has created a Community Initiatives team dedicated to recruiting participants, facilitating the meetings, and sharing the results. The results go to site leaders across the state and Sun River Health's Board of Directors.



Principle One Continued

- **Use the Community Needs Assessment (CHNA):**

MedStar Health – a not-for-profit health care organization operating in the Washington-Baltimore area – uses the CHNA, a requirement for not-for-profit hospitals, as an opportunity to perform a deep dive on the communities served. Not only does MedStar perform surveys of the community, they also host qualitative focus groups and analyze quantitative secondary population-level data and hospital utilization data to determine the needs in their communities. Individuals who attend the qualitative focus groups are compensated for their time and expertise.

Developed by MedStar Health, the 2021 Community Health Needs Assessment provides an overview of their process for and results of their 2021 Community Health Needs Assessment. The assessment allows MedStar to better understand the local health needs, and informs their strategies and partnerships to benefit community health.



To reach a diverse audience during the COVID pandemic, MedStar released an the Community Needs Assessment in a variety of vehicles, including email distribution, touchless QR codes, flyers, postcards, paper and online surveys, text messages with a survey link, virtual meetings, and marketing campaigns. Additionally, MedStar partnered with community organizations – including local churches, YMCAs, foodbanks, and local health departments – to gather critical input from underserved and at-risk populations.



Principle Two

Person-centered, value-driven health care organizations actively pursue health equity for all. Such organizations recognize the impact of structural racism and other systems of oppression on health care access and delivery, and recognize the role they play in identifying and addressing existing inequities.

According to CMS, health equity is the “attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.” This is a priority for CMS as seen in their 2022 Health Equity Strategy, which builds health equity into the core functions of CMS. Just as CMS is working to embed health equity in all policies and programs, the following organizations have invested in achieving health equity:

Employ Diverse Staffing Practices

- **Develop Diversity-Focused Internship Programs:** Sun River Health works to improve diversity in their hiring practices by hosting internships with individuals from local community colleges. This partnership provides opportunities for individuals who may not have previously been able to engage with Sun River Health to better understand the organization and its mission and operations. Participating in an internship with the center leads to a higher chance of retaining individuals from the community for full-time employment post-graduation.
- **Invest in Long-Term Partnerships:** CommonSpirit Health – a large non-profit hospital system - partnered with Morehouse School of Medicine, one of only four historically Black medical schools operating in the United States, to develop and train more Black physicians. The partnership dedicates \$100 million over ten years to establish five new regional medical school campuses and graduate medical education programs in at least ten markets connected to CommonSpirit Health. By investing in the development of a more culturally diverse workforce, CommonSpirit will be able to provide culturally congruent care to a larger number of patients.

Address Social Determinants of Health (SDOH)

- **Leverage Technology to Connect Patients with Community Supports:** “Find Help,” formerly known as Aunt Bertha, is a platform to connect health systems with community-based organizations (CBOs). This partnership allows health systems to refer patients out to CBOs (such as housing agencies, food pantries, etc.) to address the patients’ social needs. Find Help also allows CBOs to ‘close-the-loop’ with the health system by letting the referring provider and care team know when the patient was seen.



Anthem - a national health insurance company - is focused on making Find Help available across all lines of business. To encourage greater use of the tool in their Medicaid plans, Anthem provides a financial incentive to providers based on the numbers of referrals in the system. Providers receive a greater incentive if they follow up with the patient after the referral.

Similarly, Trinity Health - a not-for-profit health system based in Michigan - uses Find Help to facilitate closed-loop referrals with CBOs. The community resource directory is posted directly on their website for consumers to be able to search for CBOs that best meet their social needs. Noting the education component to understanding and using the tool, Trinity Health developed community training resources and a communications strategy to raise awareness and engage CBOs to join the platform.

Principle Two Continued

Establish Anti-Racism Education

- **Implement Anti-Racism Training for all System Levels:** Mass General Brigham (MGB) – a Boston based not-for-profit hospital and physician network – announced their United Against Racism strategy focused on bringing the system to a higher level of leadership and accountability in addressing and dismantling racism. MGB launched their first system-wide anti-racism educational program titled “Stepping Stones,” which shows how racism exists and functions in society, and how employees can combat it. Within three days of the program launching, 2000 people went through the Stepping Stones curriculum.
- **Create Standardized SDOH Screening Tools that Integrate with Existing Technology:** Pre-pandemic, MedStar Health began developing a set of standardized screening questions to use in their hospitals across their Washington, DC and Maryland service areas. After vetting several options, MedStar settled on a standardized eight question tool validated by the National Academy of Medicine. Learning how to use this tool became part of the onboarding process for the Community Health Department, where individuals would spend time role playing and learning motivational interviewing and listening skills. In practice, data is typically collected by community health advocates. FindHelp – which has been embedded into their EHR – is available to the care team to find and make referrals to the appropriate CBOs.

An ongoing challenge of data collection efforts across the health care system is making sure that patients understand the benefits of data collection to their care and addressing any concerns they may have. As data collection efforts become the norm, patient awareness and education are critical to maximizing the program’s success.

- **Establish Meaningful Community Partnerships:** In 2016, Trinity Health created the “Transforming Communities Initiative” (TCI) to improve the health and wellbeing of communities through community partnerships. Eight grantees – made up of a local participating Trinity Health hospital, a CBO, and a TCI-funded program director - were selected to participate in the four-year program. The program awarded over \$19 million in grant funds to the grantees.



The project originally focused on implementing evidence-based strategies related to tobacco use and childhood obesity but evolved to address a broader range of community needs. With the grant funds, TCI sites were able to accelerate existing initiatives and introduce new ones relating to addressing social needs. Participating sites also reported the ability to build capacity to maintain the focus areas once the program ended in 2020.

Health Equity Roadmap for Health Care CEOs: Part 1: Patient Outcomes & Experience

Developed by the Health Evolution Forum, this resource focuses on improving patient outcomes and experience through four levels of improved data collection and reporting: (1) collect raw data on demographics and patient outcomes and experience; (2) analyze internally and create dashboards for data segmented by Race, Ethnicity, Language, and Sexual Orientation/Gender Identify; (3) embed interventions into clinical workflows to reduce disparities in patient outcomes and experience; and, (4) publicize data on patient outcomes and stratify by demographic information, and establish clear accountability standards. The resource provides a road map with case studies and operational checklists for organizations to use.

Principle Three

Person-centered, value-driven health care organizations engage in value-based payment models that advance a simplified, easy to navigate system which provides culturally congruent care and benefits individuals, caregivers, and communities.

Care coordination is a key element of person-centered, value-based care, and is linked to both improving outcomes and reducing costs. Coordination requires significant time and resources, however, and has traditionally not been reimbursable under fee-for-service models. Value-based payment offers flexibility and resources to allow stakeholders to create infrastructure and reimagine workflows, making care coordination a core pillar of care delivery. Several organizations employ best practices critical to principle three:

Partner with and Invest in Patient Navigators

- **Partner with the Community to Combat Medical Mistrust:** Sun River Health's "Promotoras" program encourages individuals who have received care from the FQHC to act as messengers to discuss their care experiences with the community. This program seeks to combat broad mistrust in the medical system, as trusted members of the community are able to speak to their own patient care experiences. The Promotoras program has since expanded into a larger program that recruits Promotoras individuals to volunteer with Sun River Health for four to five hours per month. These individuals receive a full on-boarding training and stipend for their time. Several of these volunteers have since committed to working full time for the organization in a health promoter capacity.
- **Invest in Community Health Workers:** Acknowledging the power of community health workers (CHWs) in coordinating and improving care for their patient population, Trinity Health is focused on developing a standard CHW hiring procedure. To create standards for the job description, pay grade, and training to support new CHW hires, Trinity Health consults with individuals across their population health, patient experience, and community health and wellness teams.

Recognize Communication Barriers and Health Literacy Challenges

- **Create Accessible Resources:** As a FQHC, Sun River Health is required to provide materials at a fifth grade reading level and in a specific subpopulation's language once that subpopulation meets a certain percentage of the total population. Initially, Sun River Health noticed that when translated from English, their materials represented a college level of writing and reading. The Chief of Communications is charged with ensuring materials are at the correct reading level across all languages.

Establish Meaningful Cost Transparency

- **Share Cost Information Directly with Patients:** Sun River Health is federally required to send out cost information for a patient's upcoming visit 10 days prior. Information can be mailed out, transmitted electronically, or given to that patient in-person.
- **Utilize Patient-Facing Apps for Cost-Sharing:** At Trinity Health, patients have access to MyChart – an app contracted to work in tandem with their EHR system – to view information about the price of their upcoming visit or procedure. Instead of relying on the patient knowing a CPT code or name of service, the app provides a drop-down menu of options of services for the patient to select. A challenge is that the app is only accessible on smartphones, which are not universally available.

My Diverse Patients

Anthem Inc. created a resource-rich website to help educate providers on topics relevant to providing culturally competent care and services for diverse communities. Topics covered include building trust with patients; promoting birth equity; moving toward equity in asthma care; understanding sex, gender, and sexuality; and more.

Principle Four

Person-centered, value-driven health care organizations facilitate continuous quality improvement procedures that incorporate quantitative and qualitative patient feedback and patient-desired outcomes representative of diverse populations.

Centering the patient's voice is imperative in every step of their care, including quality improvement strategies. Patient-reported outcomes - defined as "any report of the status of a patient's health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient's response by a clinician or anyone else"ⁱⁱ - allow health organizations to gather feedback directly from patients to address the patient's unique care goals, and inform the organizations broader quality improvement strategies. The following strategy exemplifies principle four:

Developing and Implementing Patient Reported Outcome Measures

- **COVID Clinic Success:** MedStar Health utilizes third party vendors to provide a platform for collecting patient-reported outcomes (PROs). The health system started a post-COVID clinic during the pandemic to work with people experiencing long COVID. MedStar Health directed the clinic's team to develop a list of symptoms to track for the patients, which was then turned into a short questionnaire emailed to patients prior to their visit, as well as two, four-, and six-months post-visit. Care was taken to ensure that the surveys were distributed in an easy-to read format. The surveys asked about SDOH, quality of life, symptoms, and the impact of symptoms on work productivity. Once data are collected from patients, the information is put in the patient's care plan to track improvement over time. The program began in 2021 and continues to operate in 2022.



User's Guide to Implementing Patient-Reported Outcomes Assessment in Clinical Practice

Developed by the International Society for Quality-of-Life Research, this guide is geared towards clinicians interested in using patient-reported outcome measures in their clinical practice. The guide lays out questions for the organization to address, the resources needed, and advantages, and disadvantages associated with different paths forward.

Patient Priorities Care

Patient Priorities Care is a method that helps clinicians focus all decision making and health care on the patient's own priorities. The patient and care team identify goals the patient most wants to achieve, and the care they are willing to engage in. This information can be recorded in the EHR to allow clinicians to collaborate on the patient's care.

Patient Reported Outcomes in Performance Measurement

Patient-reported outcomes are critical in creating a patient-centered approach to care management and quality improvement. Health systems and physician groups need measurement tools in place, known as patient-reported outcome measures (PROMs), to assess patient-reported health status domains. To measure the chosen PROMs, health systems must implement patient-reported outcome performance measures (PRO-PMs), performance measures that collect data on the PROM implementation and effectiveness. Together, PROMs and PRO-PMs assess the value of care provided to the patient from the patient's perspective, while also integrating patient perspective into assessments of quality and provider performance. This guide provides a roadmap to provide guidance on developing digital PRO-PMs, intended for both novice and advanced measure developers.

[ii]https://www.qualityforum.org/Patient-Reported_Outcomes.aspx

Principle Five

Alternative payment and care delivery models are designed to effectively facilitate communication and data sharing between individuals and their caregivers, their care teams, providers, payers, and community-based organizations.

An unfortunate hallmark of our health care system is fragmentation between payers, providers, purchasers, and social services. A patient-centric organization must strive to collect complete patient demographic data, and share this – with consent – among the individual's care team and others. The following practice exemplifies principle five:

- **Health Information Exchanges:** MedStar Health partnered with the Chesapeake Regional Information System of our Patients (CRISP), a non-profit, regional Health Insurance Exchange (HIE) to facilitate data sharing between local health systems and community-based organizations (CBOs). This partnership allows MedStar Health and other health systems in the DC and Maryland area access to CRISP, which acts as a database to store all touchpoints a patient has with the health care system. Providers receive real time alerts – ‘care alerts’ - when one of their patients visits a health care site which allows them to perform outreach to ensure the patient's care is well-coordinated. Notably, CRISP also allows for data communication with participating CBOs. A CBO has access to a small amount of the patient's data (in compliance with HIPAA) and the ability to reach back out to the care team to close the loop on any referrals. While the process took several years to implement, MedStar Health has already seen a positive ROI. Over one year of assessing readmission rates, MedStar found savings of over two million dollars. An upfront investment of one million dollars is already benefitting the community and the health system.

