Vetting of the Care Delivery Perspective

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The Future Vision Workgroup was established by the ACTS Stakeholder Community to define the future vision from the four perspectives listed above. The Future Vision Workgroup consisted of 29 members from a wide range of CDOs, informatics researchers, clinical IT developers, CDS content developers, and policy organizations. Subgroups within the Future Vision Workgroup addressed each of the four perspectives (both LHS perspectives were developed by a single subgroup) and vetted the care delivery future vision with patients, care teams, and CDO leaders.

The Future Vision Workgroup met weekly by web conference to review the developing documents, provide feedback, and exchange ideas among the groups. The purpose of the Future Vision Workgroup was to create a consensus future vision for the four perspectives to serve as the destination to be reached by executing the stakeholder-driven ACTS Roadmap. Each perspective subgroup added specificity to the broader healthcare goal of achieving the Quintuple Aim. The Future Vision Workgroup sought to define a future state of healthcare that is so compelling that anyone with a stake in the future vision perspectives would be motivated to work toward achieving that future vision as part of Roadmap execution efforts.

The guiding principles of the future vision are to:

1. Use health IT to bring evidence-informed tools and resources to the point of need so they can be adopted with little or no additional effort by the user
2. Make care delivery more patient-centric by using health IT tools and methods to enhance information sharing, communication, and patient participation in care plan development and implementation
3. Use health IT effectively to improve care and care transformation processes while lessening the burden and improving satisfaction and outcomes for those involved

Care Delivery Future Vision Vetting

Staff from three organizations, VCU, the NACHC, and Health Hats (see Acknowledgements), shared the care delivery future vision for feedback with various clinical and lay stakeholders outside the Stakeholder Community to validate its core concepts and identify issues in achieving this vision:

- VCU shared the care delivery future vision with eight family medicine practices in Virginia and one health system's ambulatory QI committee, and investigators met with interviewees in person for 30–60 minutes
- NACHC shared it with a 15-member QI Advisory Board, and conducted a single 45-minute focus group by telephone
- Heath Hats shared it on a variety of social media platforms, yielding nearly 1,000 reads that generated 30 substantive comments from individuals

Respondents were sent a high-level summary of key care delivery future vision elements, a narrative of current primary care for a fictitious patient, "Mae," a second narrative of how Mae would receive and participate in her care in a future vision context, and discussion questions soliciting feedback on the future vision, what elements are already feasible, what new elements should receive priority, and obstacles to overcome.

Summary of Vetting Results

Processes used in this outreach and resulting findings are summarized in aggregate, then followed by more details for each.

Desirability of Overall Future Vision & Workflows, Tools & Resources that Support Them

In general, clinicians and patients felt the future vision was desirable, with caveats. Both groups felt attention to social needs, like social isolation, was critical. Clinicians wanted reasonable expectations and appropriate support for new care paradigms. Patients felt that there needed to be more explicit attention to patient and caregiver assumptions, concerns, and goals.

Challenges: Issues, Concerns, Requirements & Gaps to Address for Successful Implementation

The high-tech aspects of the future vision are not uniformly available (e.g., reliable internet access). Not all patients would be able or want to use them even if they were available, so workflow, paper, and relationship remain important tools. Decision aids must support true shared decision making, including attention to cost. Care plans must be functional, living documents. Any new tools and technology should make it easier for clinicians to deliver care as they are already suffering from information overload and unwieldy EHR function. The future vision also depends upon an adequate primary care workforce that is receiving support to deliver idealized models of primary care in partnership with patients and communities.

Current State: What Parts of This Can Be Accomplished Today Using Tools Available Now?

Respondents indicated parts of the care delivery future vision that could be accomplished today include communication via portal, team care models, systematic attention to prevention and chronic disease management that is evidence-based, and continued attention to longitudinal relationships between clinicians and patients as well as team-based care.

Path to the Future State: What Will It Take to Achieve the Future Vision?

Respondents indicated the most important thing necessary to achieve the future vision is a **commitment** to address all the challenges listed. Some of this will require policy changes, payment, and new technology systems that must be supported or demanded by the electorate.

Prioritization: What Parts of the Future Vision Are Priorities for Implementation Within the Next Year? In 3–5 Years?

- **Next Year:** Interoperability, HIE, and easy-to-use tools in EHRs that support EBM

- **3–5 Years:** Better resources to address social needs, universal internet access, and an expanded and well-supported primary care workforce
    - VCU Individual Vetting Processes & Results

Who? What Entities/Roles Will be Exposed to ACTS Future Vision for Feedback?

Those exposed to the ACTS Future Vision included primary care clinicians from across Virginia, both health-system-owned and independently owned. Altogether, eight practices were visited from northern and southeastern Virginia, along with a focus group of the ambulatory QI committee for a large system in southwest Virginia.

How? To What Scenario Elements Will They Be Exposed & How Will This Be Conveyed?

Staff shared the Mae current scenario, the Mae future vision scenario, and the questions that made up our interview guide in advance of a site visit. Staff recorded all interviews, had them transcribed, and provided the transcripts to qualitative researchers in our department (Family Medicine and Population Health) who did the primary analysis. Tony Kuzel and Alex Krist did secondary analyses and edited the final report.

When & Where? When/Where Will This Exposure Happen?

All site visits and interviews were conducted in late July and most of August 2019.

What? What Data/Feedback Will Be Sought From Respondents & How Will It Be Documented?

Respondents listed tools and strategies currently in use for similar patients, feedback on the future vision, essential steps to achieve it (short- and long-term), and knowledge/use of AHRQ tools to enhance primary care.

VCU Feedback Summary

Desirability of Overall Future Vision & Workflows, Tools & Resources That Support Them

All respondents felt the future vision was desirable and would result in better care for Mae and a better care experience for her, her lay support team, and professional care team. Some thought that a subset of patients would only want in-person interactions and would struggle with IT-based interventions.

Challenges: Issues, Concerns, Requirements & Gaps to Address to Successfully Implement

Respondents cited several challenges: lack of adequate attention to non-medical needs that affect health; lack of universal internet access; lack of IT interoperability; inadequate primary care workforce; inadequate support for primary care function; current technology often not easy to use and doesn't support needs; lack of payment models to support future vision care.

Current State: What Parts of This Can Be Accomplished Today Using Tools Available Now?

Respondents indicated the following could be accomplished with tools available today: communication via portal, team care models, systematic attention to preventive services, and chronic disease management that is evidence-based.

Path to the Future State: What Will It Take to Achieve the Future Vision?

Respondents indicated the future vision could only be achieved with a commitment to address all the challenges listed above, some of which will require public support (electorate) for needed policy changes.

Prioritization: What Parts of the Future Vision Are Priorities for Implementation Within the Next Year? In 3–5 Years?

- **Now:** Interoperability/HIE function; building in easily used tools to support EBM in EHRs
- **Later:** Universal internet access, adequate primary care workforce, adequate resources to support ideal models of primary care

What Are We Missing? What Other Issues Are Important That We Haven't Addressed?

Respondents indicated the care delivery future vision should also address the linkage between the self-directed IT-based interventions with direct support from the personal clinician and care team.

NACHC Individual Vetting Processes & Results

Who? What Entities/Roles Will Be Exposed to ACTS Future Vision for Feedback?

NACHC extended the opportunity for feedback to its 15-member QI Advisory Board, representing a geographically diverse, national cross-section of health centers, primary care associations, and health-center-controlled networks.

How? To What Scenario Elements Will They Will Be Exposed & How Will This Be Conveyed?

NACHC sent its advisory board a version of the future vision, including the Mae current state and future vision scenarios adapted from VCU's write-up.

When & Where? When/Where Will This Exposure Happen?

NACHC hosted a virtual feedback session August 26, 2019. QI Advisory Board members received a future vision concept document in advance of the call, which included discussion questions.

What? What Data/Feedback Will Be Sought From Respondents and How Will It Be Documented?

QI Advisory Board members were asked to provide feedback on the areas outlined by the workgroup (desirability, challenges, what's missing, etc.). Jerry Osheroff facilitated the discussion. NACHC opened the call, managed logistics, took notes, recorded the discussion, and shared notes back with the ACTS Project team.

NACHC Feedback Summary

Desirability of Overall Future Vision & Workflows, Tools & Resources That Support Them

Participating members of NACHC's QI Advisory board expressed overall interest in the proposed future vision state, with one individual noting, "It is a wonderful case study, and the person-centered approach is very much aligned with the care delivery model we are working hard to create." Another stated: "As a primary care provider, I always very much enjoy seeing what the future can look like and what could potentially be supported. It's very exciting to see where you're going with this."

Challenges: Issues, Concerns, Requirements & Gaps to Address to Successfully Implement Future Vision Workflows/Tools

A majority of members expressed caution, pointing to issues of accessibility, patient-centeredness, resource constraints, and community integration. There was consensus that the vision was "highly digitized," with a potential overreliance on technology that might be supplemented by greater consideration of workforce, policies, and community resources.

Accessibility

Nearly all participating QI Advisory Board members highlighted potential accessibility barriers for patients in the future vision. Comments pointed to the importance of considering health literacy, language, and patient access to and comfort level with technology. Key ideas included:

Language Interpretation:

- "I'm in a practice where probably 75% of the time my visits are interpreted, and so when we talk about these tools, I think they're great, but are they really going to be accessible to everyone?"
- "Many of us had concerns about the accessibility of some of the standardized tools like CAHPS surveys for patient experience. AHRQ had developed a toolkit that my understanding was to help with organizations that had the resources to be able to make the tool accessible for other languages...[but] it almost felt like [payors] had a choice whether or not they actually did that."

Health Literacy:

- "I've read through the future scenario. It sounds so highly digital... We deal with a lot of populations that have whether it's cultural or language or other limitations or literacy. ...even for people who can read and access all the information, how we move people along or get them to that understanding... it's a big leap of faith for me."

Resources

Multiple advisory board members raised the question of reimbursement, recognizing that discussion of a future vision of care cannot be wholly separated from resource considerations—both in terms of money and time. They encouraged ACTS to acknowledge that implementing comprehensive interventions requires time and to consider how proposed services could be reimbursed.

- "We try to do much of the same thing but are limited with some of the technological aspects because those services are not able to be reimbursed. The reimbursement model also makes it difficult to invest the time necessary for such comprehensive interventions."
- "…the issue of resources is outside of the scope of this discussion...but I think that really is a big driver in how priorities get set sometimes, unfortunately."

Partnership/SDOH

Participants stressed that an ideal future vision state must integrate community-based resources and facilitate partnerships between care teams and community services to better address patients' comprehensive needs, including SDOH.

One individual specifically identified "home visits by community health workers" as a missing element of the proposed vision: "Health centers are working to address social determinants of health of patients and working a lot with community partners outside the four walls of the health center. How the care team can have those very productive relationships with community partners will be an important part [of the Roadmap] as well."

Patient Centeredness

Advisory board members commented on the importance of framing the future vision around the patient and her needs and preferences. One individual identified his highest priority interventions as: 1) shared decision-making tools, and 2) patient education and self-management tools. Another participant observed that the current and future states described in the sample patient scenario both put the onus on the patient to take action; instead, she suggested that the future vision present a more proactive role for providers.

- “What’s missing [from the proposed future vision]: understanding of Mae’s motivations for improving her health, other options in case Mae isn’t comfortable with telehealth and how she would best like to receive care.”
- “In both [scenarios] it seems to be that it's up to the patient to be the one that reaches out. While in the second scenario there are other options in which to do this. The observation I make is that we currently...have tools that could make it possible for us to be more proactive and not wait for the patient to initiate the request.”

Other

Advisory board members also stressed that a roadmap for transformation must accommodate different care settings and have the ability to be applied flexibly depending on workflows and needs: “... a lot of these tools were developed in more of a research type of setting and so translating them into primary care with a safety net population... there's going to be some nuances for how that needs to happen...Just having those tools laid out so that they can be implemented in such a way that works best for the care team... and some examples or model practices that an organization could consider depending on their workflows because it's going to look different depending on their workflow.”

Another participant commented that the proposed “Integrated Care Plan” lacked standardization: “seems like there's no standard, nor standard definitions, nor standard terminology, nor standard way of sharing that.”

Current State: What Parts of This Can Be Accomplished Today Using Tools Available Now?

Participants also observed that, in many senses, they were already familiar with the components that are described in the proposed future vision state. One individual suggested that instead of identifying what care elements we should be moving toward the question would be better framed as, “why aren’t we there yet?”

“When I look at the list that's in the table that has 19 items on them, all of those actually seem pretty familiar to us in the health center world. I don't mean to speak for everyone, but I think that we all look at these and we know what they mean. What that says to me is, to some degree, the future is already here, it's now, and so what's the reason why we're not really realizing the full benefits of all these things?”

Path to the Future State: What Will It Take to Achieve the Future Vision?

See Challenges: Issues, Concerns, Requirements & Gaps to Address to Successfully Implement Future Vision Workflows/Tools.

Prioritization What Parts of the Future Vision Are Priorities for Implementation Within the Next Year? In 3–5-Years?

No input

What Are We Missing? What Other Issues Are Important That We Haven’t Addressed?

One advisory board member also raised the importance of better leveraging AHRQ’s evidence-based resources to inform public policies that impact patients: “There's a lot that we know that's evidence-based that could actually better inform public policy... things like policies that could better promote physical activity or access to healthy foods...[that] have more to do with what the community structure and infrastructure is like.” Please also see B. 3.9.3.5.2, Challenges: Issues, Concerns, Requirements & Gaps to Address to Successfully Implement Future Vision Workflows/Tools..

Health Hats Individual Vetting Processes & Results

Who? What Entities/Roles Will Be Exposed to ACTS Future Vision for Feedback?

Respondents were exposed to the ACTS Future Vision via LinkedIn (1,700 connections, 414 views, patient/caregiver activists, clinicians, academics, developers), Twitter (710 followers, 430 reads), Facebook (HealtheVoices (23 reads), Society for Participatory Medicine (15 reads), PPICOnline (91 reads), Engagement Buddies (21 reads), WEGO Health), and 30 other substantive comments were received via mediums used, emails, and phone calls.

How? To What Scenario Elements Will They Be Exposed & How Will This be Conveyed?

Health Hats posted the Mae current state and future vision scenarios and discussion questions.

When & Where? When/Where Will This Exposure Happen?

Respondents could access the future vision materials July 30–August 9, 2019 on social media (LinkedIn, Twitter, and Facebook).

What? What Data/Feedback Will Be Sought From Respondents & How Will It Be Documented?

Health Hats complied replies collected via direct message, text, and email.

Health Hats Feedback

Desirability of Overall Future Vision & Workflows, Tools & Resources That Support Them

In general, this future vision was considered desirable.

Challenges: Issues, Concerns, Requirements & Gaps to Address to Successfully Implement

- Education must include understanding patient and family caregivers' concerns and assumptions (e.g., that any findings on an MRI or other imaging mean docs know the cause of pain)
    - Also missing how to address the emotional aspect that causes people to make decisions too quickly or presume more invasive options must be more effective
- Decision aids on their own are not effective. Clinicians must also be trained in SDM, or decision aids can create problems and can disintermediate the patient/clinician relationship
    - Most decision aids are unable to address cost/coverage issues, and clinicians are often unable to give clarity into this as well
    - Clinicians also need to be familiar with what's in the decision aid, which usually includes options outside their specialty and rarely includes integrative med options
- Online decision aids exist, and can be prescribed, but too many of them assume health literacy with an existing condition
- When a care plan/treatment journal is completed or updated who does this?
    - Is there a common repository for all the information, similar to Google docs where multiple people have access to read and edit/add?
    - This information is a living document; how would this work?
    - There would be a lot of consents completed to include many family members and community partners to access the document potentially
    - I think this is a great idea and will require people to really think of functionality without the current constraints, rather what it could be and try to remove constraints if they are too restrictive

Current State: What Parts of This Can Be Accomplished Today Using Tools Available Now?

No input

Path to the Future State: What Will It Take to Achieve the Future Vision?

- I wonder if clinicians should be asking (who are your three or five who would drop everything and be there for you no matter what)
    - If answer is "not sure or don't know"—how might clinicians help solve?
    - I think social isolation is a serious and growing epidemic
    - I wonder if clinicians were to ask some version of, "Who are you going to tell about your visit and what are you going to say?" would that check for loneliness and check for the most important thing discussed?
- Have you discussed using NQF's patient passport, or AHRQ's question builder to help frame conversations between clinicians and patients?
    - I am a bit concerned with reliance on electronic means of communication especially for elderly and potentially disadvantaged patients who may not have access to or understand the technology
    - Is there a paper alternative if need be or will patients be provided training in accessing electronic means?
    - Need to include community pharmacies as a piece/entry point for this as many patients go there first for advice on meds
- Maybe an enhanced medication report, one that's color coded and written in everyday LR language like hypertension med= image of heart and called "Heart meds" and opiates have a notation about addiction risks and short-term use?
- com makes it easy for patients to share what matters to them.

Prioritization: What Parts of the Future Vision Are Priorities for Implementation Within the Next Year? In 3–5 Years?

No input

What Are We Missing? What Other Issues Are Important That We Haven't Addressed?

- What if patients/families were directly invited to help tackle some of the main issues affecting a clinic/hospital (e.g., we are struggling with staffing, what ideas might a patient from another industry bring)?
- What if all clinicians sought out "patient/family" mentors and sought them out the way they do with medical faculty mentors?
- Info about cost and coverage, which is variable and very tricky
- I would like to see something in here about Mae's values and goals
    - Perhaps she prefers to try non-pharmaceutical options first, or perhaps she is working toward a specific health goal that she would like all of her care providers to support
    - We tend to frame care plans as being about what we (the health system) want for the person, not what the person wants or him/herself
- Also, there should be a goal about reconciling and clarifying any conflicts in the instructions she receives from various doctors
- If Mae wants, she should also be able to contribute a version of her medical history
- Incorporate contextual education so Mae can get educated as she looks at her data from lab results to conditions to medication