Making Measures Personal

Positioning Patient Stories to Paint a Poignant Picture

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Agenda

- Welcome and Why Stories Matter
- Informing QI with Patient Voice
- Illustrating Impact: A Case Study
- Facilitator Tools and Tips
- Table Talk and Take-aways

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Why Personalization Matters

Data-Only View

Practice Glycemic status assessment improved 4% over the last month.

- Feels distant from daily clinic workflow
- Easily dismissed as population shift
- Motivates compliance not ownership

Personal View

Marie logged her blood sugar daily and she started walking daily with her dog her A1c improved by .3

- Connects directly to care team action
- Hard to dismiss because it was the experience of a person known to the team
- Motivates pride and repeat effort

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Part I: Informing Quality Improvement with Patient Voice

Listening Before Redesigning

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Patient and Family (Caregiver) Advisory Councils

What a PFAC Is

- Patients, family members, and caregivers who meet regularly with practice leadership
- A structured, ongoing channel. Not a one-time survey
- Members reflect the population the practice serves, including those who aren't thriving

How PFACs Feed QI

- React to proposed measures: “Does this actually reflect what matters to you?”
- Surface barriers staff can't see like transportation, food insecurity, health literacy, trust
- Co-design the change idea, not just approve it after the fact
- Provide a steady pipeline of stories for Steps 1–2 of the 7 Stories process

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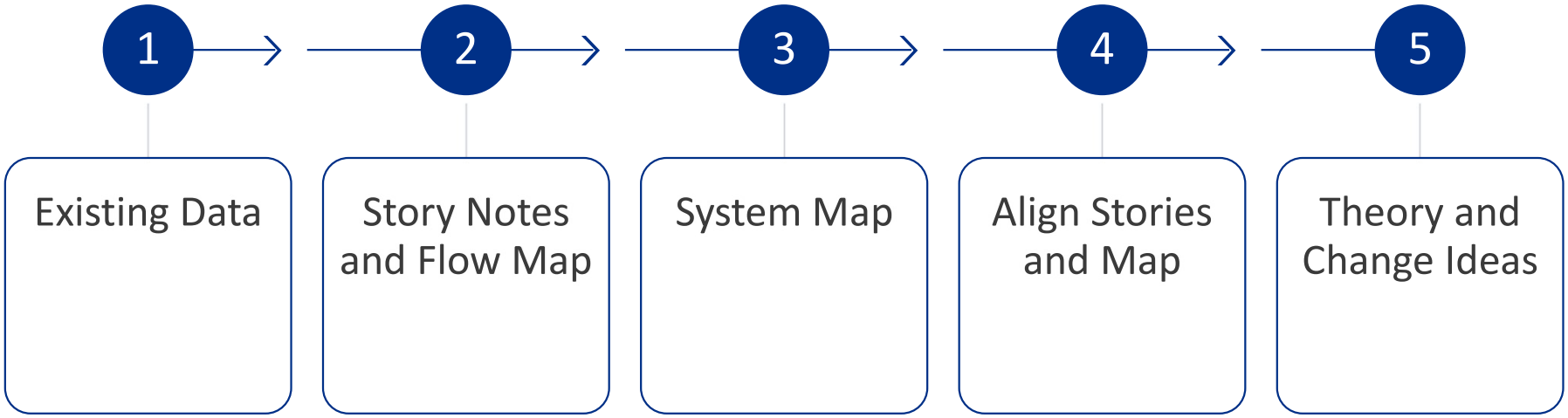
IHI “7 Stories” Process



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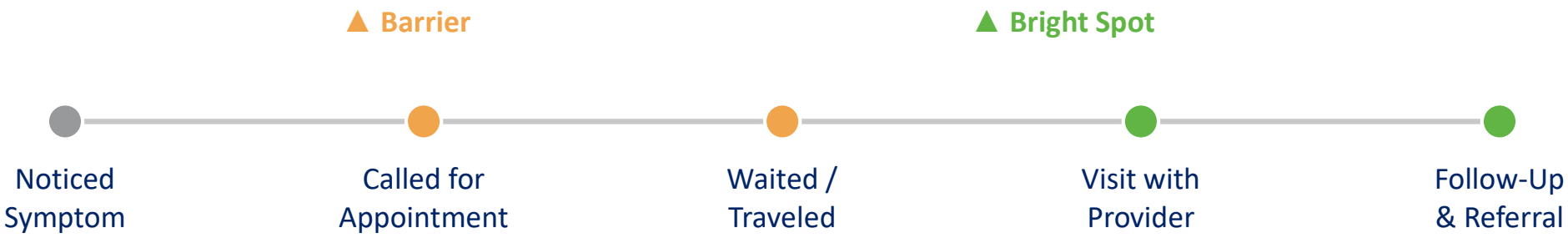
Journey Mapping



- Ask the patient (or staff, recounting the patient's story) to narrate each step in order
- Mark where things went smoothly and where friction, delay, or confusion happened
- Plot alongside the 7 Stories “beginning – middle – end” structure from Step 2

- Makes an abstract process concrete and visible on one page
- Helps a team spot the exact step to target with a change idea
- Easy to redo with a second or third story to check for patterns

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Part II: Illustrating Impact

Case Example Mapping Stories to Outcomes

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Quantitative Process or Lead Measures

Quantitative: Lead Measures	Measure Description
	Learning Path (CM Training) Completion Rates by Module/Course • Essentials of Care Management via HealthTeamWorks Online Learning Management System
	Care Manager Caseload • Member count/CM (with ability to drill down into member list by CM)
	Collaborative Care Plan • Number of active care plans/number of members enrolled in CM
	Number of CM interactions with enrolled members • In-person, telephonic, virtual, other
	Revised to start with Member Engagement • Incremental levels (e.g., enrolled, interactions scheduled/happening, care plan established with SMART goals, graduation/monitoring)
	Testing and Screening • Evidence-Based Guideline (EBG) care testing rates (e.g., A1c) • BH Questionnaires (e.g., PHQ, GAD) completed per established guidelines • Social determinants of health (SDoH) screening
	Utilization • Tracking ED and admission rates for members enrolled in CM

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Quantitative Outcome or Lag Measures

Quantitative: Lag Measures	Measure Description
	Total cost of care (TCOC) • Tracking TCOC comparing members enrolled in CM and those not enrolled in CM
	A1c Control • Measure definition aligned with 2022 organizational scorecard

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Qualitative Data The Stories

Qualitative Data

Measure Description
Regular capture of stories organized by themes such as: • ED and/or admission diversion • Engagement and activation (self-management) • Culturally responsive care • Member experience (anecdotal) • Provider and staff experiences

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Case Study: Primary Care Group Risk Stratified Care Management

Enrolled in CM

41 → 181

Eligible for CM

38 → 63

Declined CM

24 → 26

Feb 2023

Six months later

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Qualitative Data

Qualitative Data - Stories from the Field			
Date	Care Manager	Theme *(drop down function to sort)*	Narrative
4/5/22	Care Manager name	ED Diversion	*Enter description here - document examples from each CM/Care Guide-RN during weekly teaming meetings. Results gathered over time can be sorted by theme.*
4/14/22	Care Manager name	Avoided Admission	
4/27/22	Care Manager name	Avoided Readmission	
5/10/22	Care Manager name	Improved Quality Metrics	
5/23/22	Care Manager name	Re-Engaged	
5/13/22	Care Manager name	Other	
5/31/22	Care Manager name	Avoided Readmission	
6/23/22	Care Manager name	ED Diversion	
6/19/22	Care Manager name		

ED Diversion
Avoided Admission
Avoided Readmission
Improved Quality Metrics
Re-Engaged
Other

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Case Study: Dashboard to Narrative

1. Spot a Signal
2. Capture the Story
3. De-identify and Share
4. Pair with the Data

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Story: Highest Risk Score at Launch

Baseline

- Living with Type 2 diabetes, myasthenia gravis, pulmonary hypertension, CHF, Stage IV renal failure
- Started the Care Management program with the highest risk score in the entire population
- 24 active medications, frequent ED visits, often resulting in admission

Outcome

- Now sees her provider monthly, including a dedicated CM visit
- Increased engagement with both CM and her PCP has reduced both ED utilization and inpatient admissions

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Story: “This is a game changer. I can’t thank you enough.”

Baseline

- Enrolled in CM with diabetes, CKD, hypertension, hyperlipidemia, and prostate cancer
- Struggled with medication costs and wanted a CGM but didn't qualify under his plan

Intervention

- CM discovered an unused Medicare Advantage benefit with full Rx coverage and explained it in plain terms
- CM also coached him through using a new glucose meter and lancet device

Outcome

- Provider noted improved engagement
- He finally agreed to see a Diabetes Care Specialist
- A1c 8.8% at last check
- Patient lost 8 pounds since first CM engagement

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Story: A Full Team Effort

Baseline

- 60-year-old man living with behavioral health diagnoses and Type 2 diabetes
- His diet consisted of mostly ramen noodles or canned soup, eaten inconsistently due to low income

Intervention

- CM referred him to a Diabetes Care Specialist and community partners for local food assistance
- Practice Team and the Community Care Hub all contributed to the plan

Outcome

- He hadn't realized how much sodium in that diet was affecting his health
- Team noted he seemed “happier and more energetic than ever before”
- A1c 10.2% to 6.8%

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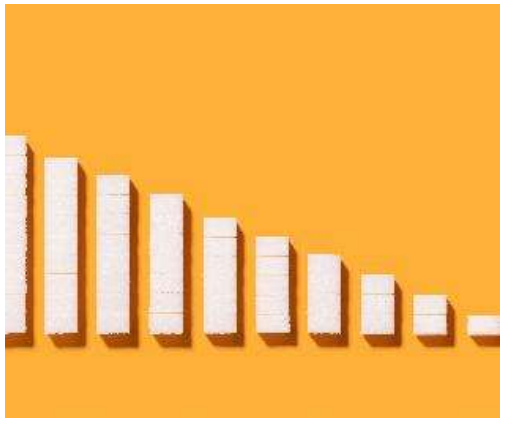
What Makes These Stories Work



Specific Number

"Risk score dropped 3 points," not "she's doing better." Ties the feeling directly back to the measure.

Patient's Own Words

A direct quote, even one sentence, evokes more feeling and connection than a paragraph of clinical summary.

A Named Barrier

Cost, health literacy, food access, device confusion.

Name the obstacle the team helped the patient move or overcome.

Always De-Identified

No names, no dates that could identify someone, no unnecessary detail. Every time, no exceptions.

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Facilitation Tips

1. Pick a capture point that is low-hanging fruit
2. Use a simple prompt
3. Pair every story with a number
4. Build the de-identification habit early
5. Bring stories back to the team, not just leadership

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