New Era Of Patient Engagement

Susan Dentzer
Editor-in-Chief
Health Affairs

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Keynote

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Assistant Secretary for Health
US Department of Health and Human Services

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An Overview Of The Evidence And Potential For Patient Engagement

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What The Evidence Shows About Patient Activation:

Better Health Outcomes And Care Experiences; Less Data On Costs

Judith Hibbard, DrPH
Jessica Greene, PhD

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Why Invest In Patient Engagement Or Patient Activation?

- Reviewed findings from over 100 studies that quantified patient activation
- Higher activated individuals are more likely to engage in positive health behaviors and to have better health outcomes
- Activation also linked with better care experiences

Studies Show That Targeted Interventions Can Increase Patient Activation

- Effective interventions have:
  - Utilized peer support
  - Changed the social environment
  - Increased patient skills
  - Tailored support to the individual's level of activation
- Increased activation translates into improved outcomes

Delivery System Innovations

- Using patient's activation level to tailor care– meeting patients "where they are"
- Allocating resources differently based on both clinical and behavioral profiles
- Increasing patient activation viewed as an intermediate outcome of care

A Multidimensional Framework For Patient And Family Engagement In Health And Health Care

Kristin L. Carman, PhD
American Institutes for Research
February 6, 2013

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Why This Framework?

- Clarify definition
- Distinguish concept from related but not synonymous concepts
- Define the range of patient and family engagement
- Ground current diverse efforts in appropriate theory and evidence

A Multidimensional Framework For Patient And Family Engagement In Health And Health Care

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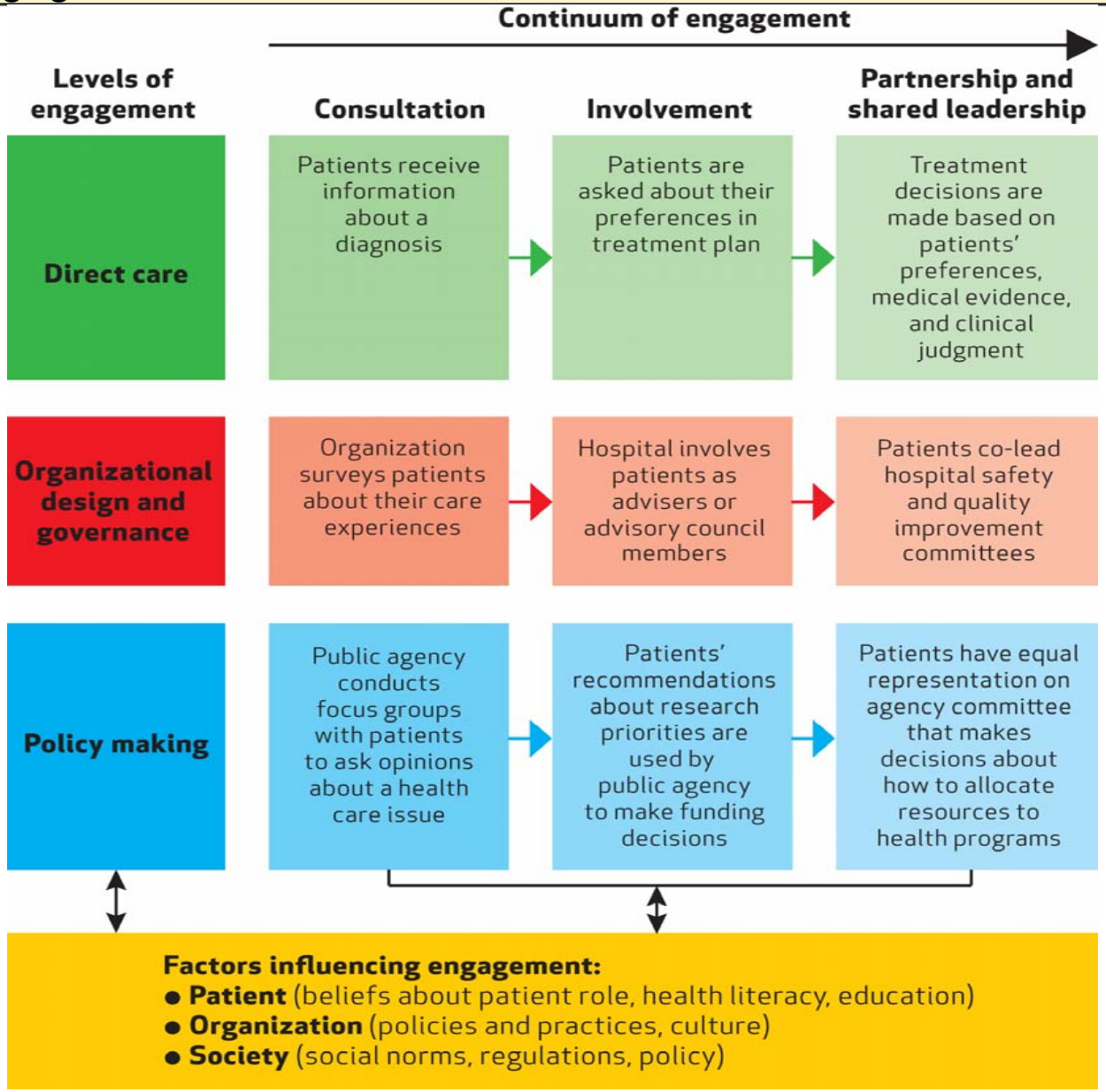

Using This Framework

- **Policy-making**
  - **Align policies, programs, and funding to engender engagement**
- **Practice**
  - **Identify opportunities, impediments, and success strategies**
- **Research**
  - **Develop and evaluate interventions**
  - **Identify areas most likely to impact practice**
  - **Partner to create measures to assess improvement**
- **Advocacy**
  - **Ensuring all of the above**

Contact And Co-authors

Kristin L. Carman
American Institutes for Research
Kcarman@air.org
www.air.org

Co-Authors:

- **Pam Dardess, American Institutes for Research**
- **Maureen Maurer, American Institutes for Research**
- **Shoshanna Sofaer, Baruch College, City University of NY**
- **Karen Adams, National Quality Forum**
- **Christine Bechtel, National Partnership for Women & Families**
- **Jennifer Sweeney, National Partnership for Women and Families**

How The Patient-Centered Outcomes Research Institute Is Engaging Patients And Others In Shaping Its Research Agenda

Joe Selby, MD, MPH

Executive Director

Patient-Centered Outcomes Research Institute

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Ten Strategies To Lower Costs, Improve Quality, And Engage Patients:

The View From Leading Health System CEOs

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI
President, Clinical and Physician Services Group
and Chief Medical Officer, HCA

On Behalf of the IOM Roundtable on Value and Science-Driven Healthcare:
Delos M. Cosgrove, Cleveland Clinic
Michael Fisher, Cincinnati Children's Hospital Medical Center
Patricia Gabow, Denver Health and Hospital Authority
Gary Gottlieb, Partners HealthCare
George C. Halvorson, Kaiser Permanente
Brent C. James, Intermountain Healthcare's Institute for Health Care Delivery Research
Gary S. Kaplan, Virginia Mason Health System
Jonathan B. Perlin, HCA
Robert Petzel, Department of Veterans Affairs

J. Michael McGinnis, Institute of Medicine
Leigh Stuckhardt, Institute of Medicine

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Introduction

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- ***A CEO Checklist for High-Value Health Care*** **identifies 10 strategies that have been demonstrated as effective and essential to improving quality and reducing costs.**
- **Better outcomes at lower costs – better value – can be achieved through the transformative potential of patient-engaged care.**
- **The strategies identified fall into four categories:**
  - **Foundational elements**
  - **Infrastructure fundamentals**
  - **Care delivery priorities**
  - **Reliability and feedback**

CEO Checklist For High-Value Health Care

Item	Category
Governance priority — visible and determined leadership by CEO and board	Foundational elements
Culture of continuous improvement — commitment to ongoing real-time learning	
IT best practices — automated, reliable information to and from the point of care	Infrastructure fundamentals
Evidence protocols — effective, efficient, and consistent care	
Resource use — optimized use of personnel, physical space, and other resources	

CEO Checklist For High-Value Health Care

Item	Category
Integrated care — right care, right setting, right providers, right teamwork	Care delivery priorities
Shared decision making — patient-clinician collaboration on care plans	
Targeted services — tailored community and clinic interventions for resource-intensive patients	
Embedded safeguards — supports and prompts to reduce injury and infection	Reliability and feedback
Internal transparency — visible progress in performance, outcomes, and costs	

Kaiser Permanente

Healthy Bones Program

- Developed measures to identify and proactively treat patients at risk for osteoporosis and hip fractures
- Standardized practice guidelines for osteoporosis management
- Osteoporosis education and home health programs

Results

- Improved patient experience by engaging patients to become proponents of their own health
- Over five years, 30% reduction in hip fracture rates for at-risk patients

HCA

Developed evidence-base and standardized practice guidelines for perinatal services

- Fetal heart monitoring education and competency testing
- Universal screening for hyperbilirubinemia to eliminate kernicterus
- Standards for high-volume, high-risk, maternal medications (e.g., oxytocin)
- Benchmark for reducing elective, pre-term deliveries (<39 weeks gestation), based on study of 17,794 births showing NICU use at 37>38>39 weeks
- Engaged patients by "rounding" with patients in rooms

Results

- Maternal death rate that is half the national average
- $68M in system-wide savings
- Eliminating all elective, pre-term deliveries in U.S. would save > $1 billion annually

*Clark SL, et al. *Am J Obstet Gynecol.* 2011;204(4):283-287.
*Clark SL, et al. *Am J Obstet Gynecol.* 2010;203(5):449e1-449e6.

The Cleveland Clinic

Care Enhancement Program for Lung Transplant Patients

- Engaged patients through “daily huddles” with caregivers
- Consensus approach to understanding prognosis and creating shared care plan

Results

- Total length of stay reduced by 1.54 days
- 6 percent decrease in costs of care
- 28 percent improvement in patient satisfaction regarding clinicians communication
- 30-day survival improved 3%

Theda Care

Organizing Care Around The Patient's Experience

- **Upon admission, an interdisciplinary care team directly engages patients to develop a mutually agreeable care plan**

Results

- **Average length-of-stay reduced by 10%-15%**
- **95% of patients score satisfaction as "5/5," improved from 68%**
- **25% reduction in direct and indirect costs of inpatient care**
- **Reduced errors – eliminated medication reconciliation errors**
- **Improved care protocol compliance**

Cincinnati Children's Hospital Medical Center

Patient Flow Improvement

- Implemented series of operations-management interventions to improve patient flow through ICU

Results

- Improved patient experience while making care delivery more efficient
- Fewer delays and cancellations of elective surgeries due to unavailable beds
- More predictable flow of patients
- Eliminated need for 75 new beds, saving $100M in capital costs

Intermountain Healthcare

Evidence-based approach to supply chain

- Internal supply chain experts and clinical staff used clinical and administrative data to develop an evidence-based approach for identifying practices and products associated with best outcomes

Results

- Better care – 2.3% reduction in catheter-associated bloodstream infections
- Lower costs – More than $200 million in savings during the past 5 years

Virginia Mason Health System

Reduced Workflow Inefficiencies Through Rapid Process Improvement

- Nursing teams work with patient-care technicians in “cells” (groups of rooms located near each other) rather than spread across a unit

Results

- Nurses spend 90% of their time on direct patient care, compared to 35%previously, resulting in an 18% improvement in timeliness of care
- Enhanced team communication and better skill-task alignment

Partners Health Care

Connected Care Cardiac Program

- A self-management and telemonitoring program employing advanced care coordination, patient education and technology to help heart failure patients manage care at home

Results

- Increased patient engagement across care settings
- Patients self-report to telemonitoring nurses
- Heart failure hospital readmissions reduced by 51%
- Cost savings of $10M ($8,155 per patient)

Veterans Health Administration

Increasing Patient Access

- **Patient-Aligned Care Teams (PACT) use telephone clinics, home telehealth, secure messaging, and mobile apps to engage patients and improve primary care access**

Results

- **Unplanned, urgent care visits by primary care patients decreased by 8 %**
- **Total PACT encounters increased 16%**
- **Better access and efficiency: 15 % increase in same-day primary care physician appointment availability**

Geisinger

ProvenHealth Navigator (PHN)

- **Leveraged integrated health system structure – Geisinger Clinic and Geisinger Health Plan – to develop an advanced medical home model**
  - **Reengineered primary care, integrating population management in a "medical neighborhood," and supporting with quality and value measures**

Results

- **18% decrease in acute admissions and 20% decrease in risk-adjusted readmissions**
- **Increased patient engagement: 91 % of patients rate the quality of care as better than in the past**
- **93% of physicians would recommend PHN as a model**

Denver Health

Community Health Center Patient Registries

- **Report card for care of high-risk patients with one or more chronic conditions, assigned to a medical home / primary provider**

Results

- **Breast cancer screening rates increased by 20%**
- **Colorectal cancer screening rates increased by 50%**
- **Hypertension control rate increased by 12% over 3 years**
- **Urgent care visits reduced by 14%**
- **Hospital admissions reduced by 7%**
- **Patient engagement improved through better communication of care plans between clinic visits**

Conclusion

- That patient-centered care is designed around patients' needs, preferences, circumstances and well-being is central to high-value health service.
- Even among high-performing systems, the definition and measurement of *patient-engaged care* differs based on context.
- Patient-engaged care is associated with better health outcomes, better care experience for patients, and lower health costs.
- Good quality is good business. It is possible to build a patient-centered health care system and deliver high-quality care in ways that are beneficial for both patients and the bottom line.

Narrative Matters

An Accidental Tourist Finds Her Way In The Dangerous Land Of Serious Illness

Jessie Gruman

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Engagement is not nice.

It is necessary.

Engagement does not mean compliance.

Behavior matters.

- **Find Good Clinicians and Facilities**
- **Communicate with Clinicians (doctors, nurses, others)**
- **Organize Your Health Care**
- **Pay for Health Care**
- **Make Good Treatment Decisions**
- **Participate in Treatment**
- **Promote Health**
- **Get Preventive Health Care**
- **Plan for the End of Life**
- **Seek Health Knowledge**

Clinicians And Patient Engagement

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Patients, Providers, And Systems Need To Acquire A Specific Set Of Competencies To Achieve Truly Patient-Centered Care

Elizabeth Bernabeo & Eric S. Holmboe

American Board of Internal Medicine

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Shared Decision Making (SDM)

- **Physicians and patients make health-related decisions collaboratively, based on best available evidence and patients' values, beliefs, and preferences.**
- **Patient engagement through SDM is linked to increased patient satisfaction, health outcomes, and quality of decisions.**
- **Requires competency at the patient, provider, and system level.**

Patient Competencies

- Towle & Godolphin 1997; 1999
- Patients vary in degree of control and participation they desire in the healthcare process.
- Influenced by culture, age, gender, education, degree of illness, lack of knowledge, self efficacy.
- The fear of being categorized as “difficult” may prevent some patients from participating more fully in their own health care.

Physician Competencies

- Towle & Godolphin 1997; 1999

- Physicians must first agree that patients should be part of the decision-making process.

- SDM requires attitudes and skills that many physicians may not possess or be familiar with.

- Physicians may also need to negotiate their own professional biases and emotions.

System Competencies

- **Physicians' and patients' competencies in SDM require support from health care systems.**
- **Structural changes, such as new information systems to link patients with decision aids and resources, redesigned models of office care, and restructured reimbursement schemes.**
- **Systems must move toward stronger support of interprofessional collaboration and teamwork.**

Bottom Line

- A multilevel partnership among all stakeholders committed to change in health care is required.
- Policy makers can:
  - develop payment models that reward efforts to practice shared decision making and focus on value of care, rather than on the volume of services delivered.
  - modify medical education and continuous professional development to train providers in the critical competencies needed to engage patients in meaningful discussions of care.
  - help advance a more thoughtful and fact-based conversation about health care decisions.

An Effort To Spread Decision Aids In Five California Primary Care Practices Yielded Low Distribution, Highlighting Hurdles

Grace A. Lin, Meghan Halley, Katharine A. S. Rendle, Caroline K. Tietbohl, Suepattra G. May, Laurel Trujillo & Dominick L. Frosch

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Partners In Medical Decision Making Project

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- 5 primary care practices in Northern California.
- Analysis of workflow to adapt implementation to local circumstances.
- Bi-weekly academic detailing to monitor progress, consult and encourage.
- Branded nominal rewards for high utilizers.
- Promotional materials for patients in waiting and exam rooms.

Few Eligible Patients Received A Decision Aid

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- 4,055 decision aids provided to patients across 5 clinics over 21 months.
- 75.8% of these were for colon cancer screening or back pain.
  - 9.3% of eligible patients received a colon cancer screening program
  - 10.7% of eligible patients received back pain program
- Physicians provided 26.8% of decision aids to patients.

Lessons Learned

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- Physicians don't always perceive a role for patients in decision-making.
  - Don't recognize decisions as preference sensitive and don't perceive benefit of involving patients.
- Time is perceived as a major barrier.
  - But used strategically, decision support can save time.
- Clinical support staff more embracing of concept of engaging patients.

Implications

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- Physicians need better training in engaging patients in the decision-making process.
- Team-based practice model more likely to be successful.
- Quality measures need to assess and reward patient engagement.
- Incentives for patient engagement must be aligned.

Providers, Payers, The Community, And Patients Are All Obliged To Get Patient Activation Ethically Right

Marion Danis, M.D.
and Mildred Solomon, Ph.D.

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Disclaimer

The views expressed here are mine and those of Mildred Solomon and do not necessarily reflect policies of the NIH or Department of Health and Human Services

Ethical Justification For Patient Activation And Engagement

- Consonant with respect for persons
  - These strategies enhance self determination and the ability of individuals to be self actualizing
- Consequentialist reasoning
  - These strategies are likely to lead to better health outcomes

Successful Patient Activation

- Includes all patients regardless of their ability and their socio-economic circumstances
- Require the participation of many stakeholders

Patient Responsibilities

- Actively engage in pursuing one's own health
  - Appreciate the contribution that one can make to personal health
  - Engage with others to promote one's own health

Clinician Responsibilities

- Collaborate with patients to identify goals and set realistic expectations
- Provide adequate support for fulfilling these expectations

Health Care Organizations And Delivery Systems

- **Build a culture supportive of patient activation**
  - **Endorsement from leadership**
  - **Include patient representation in the boardroom**
  - **Provide evidence-driven interventions to engage patients in their own care**
  - **Collaborate with other health care organizations and organizations outside the health sector**

Insurers And Payment Systems

- Create payment incentives that are in keeping with the ethical goals of patient activation and engagement:
  - Rewards and penalties should be based on goals and outcomes that patient s have selected
  - Reimburse clinicians for offering interventions that promote patient empowerment and jointly chosen outcomes

Communities

- Communities and the places where people live, work, study, and congregate, play an important part in promoting health.
- Leadership in these setting should be expected to play a role in engaging their constituents in promoting their own health

Ethically Problematic

- Expecting patients to actively pursue without understanding their unique circumstances and without providing them with the necessary support
- Misusing the rationale of patient engagement to justify pursuits that do not achieve this goal

Patients With Mental Health Needs Are Engaged In Asking Questions, But Physicians' Responses Vary

Ming Tai-Seale, PhD, MPH

Patricia K. Foo

Cheryl D. Stults, PhD, MA

Palo Alto Medical Foundation Research Institute

NIMH R01 MH081098, NCI R01 CA112379

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Primary Care Visits

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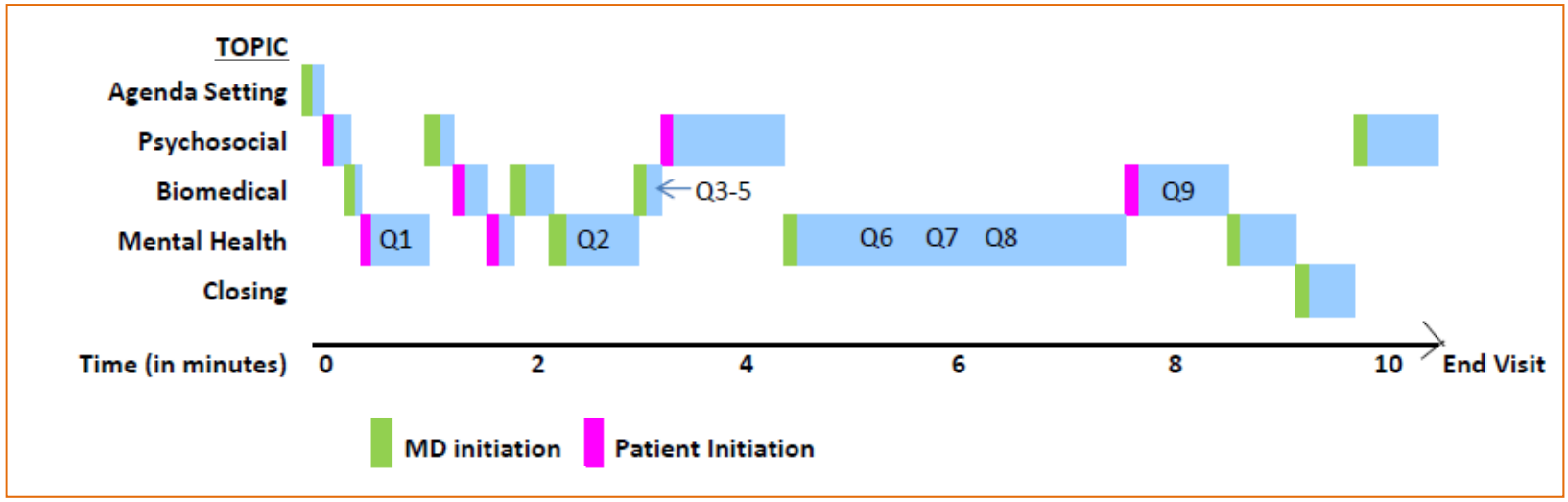
PT: I want a happy pill. *Is there such a thing?*

MD: Ah, well, you know, those anti-depressants work.



Findings

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18/visit

Lower patient ratings of physician communication quality

Slight increase in visit length

Physician Responses

- Mindful and evidence-based
- Brief
- Perfunctory ➔ missed opportunities
- Multitasking ➔ fragmented conversations

Conclusions

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Questions

Conversation

Team

Shared Decision Making

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Enhanced Support For Shared Decision Making Reduced Costs Of Care For Patients With Preference-Sensitive Conditions

David Veroff, MPP
Senior Vice President, Innovation
Health Dialog

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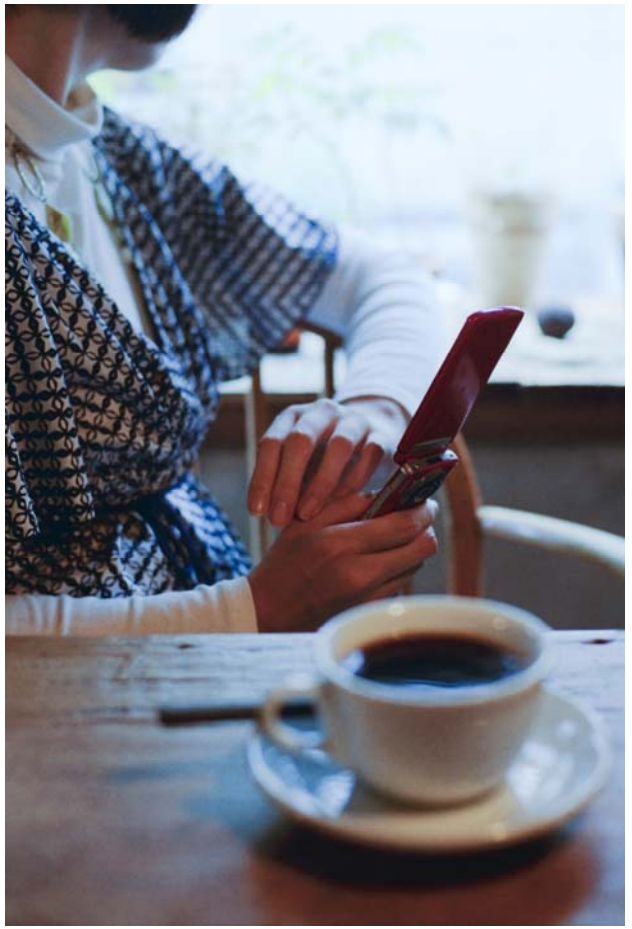
Background And Methods

- Important deficits in patient participation in decisions about their care
- Shared Decision Making improves care and patient experiences
- Conducted a randomized trial comparing two levels of telephonic support for people with conditions that involve multiple treatment options



Result: Reduced Medical Costs, Admissions

EXHIBIT 4

Study Participants' Medical Costs And Resource Use During The Intervention,

	Usual support	Enhanced support	Relative difference (%)
COSTS			
Total medical costs[a]	$436.05	$412.78	-5.3
Inpatient costs[a]	$132.73	$116.20	-12.5
Hospital outpatient costs[a]	$96.91	$92.49	-4.6
RESOURCE USE			
Inpatient admissions[b]	155	135	-12.5
Emergency department admissions[b]	409	399	-2.6
Surgeries for preference-sensitive conditions[b]	32	29	-9.9
Advanced imaging studies[b]	400	393	
Standard imaging studies[b]	1,488	1,458	

SOURCE Authors' analysis. **NOTES** Medical costs were capped at $200,000 per year. Advanced imaging includes magnetic resonance imaging, x-ray computed tomography, and positron emission tomography. Standard imaging includes standard x-rays and ultrasound. [a]Per person per month. [b]Per thousand people per year. $^{**}p < 0.05$ $^{***}p < 0.01$ $^{****}p < 0.001$

Implications

- **Prior Research: Shared Decision Making = better patient experience**
- **This Research: Shared Decision Making also = lower costs**
- **Straightforward implementation of coaching makes it possible to act now**

Implementing Shared Decision Making In Primary Care

Barriers And Solutions

Mark Friedberg

Kristin Van Busum, Richard Wexler, Megan Bowen, Eric Schneider

Supported by the Informed Medical Decisions Foundation

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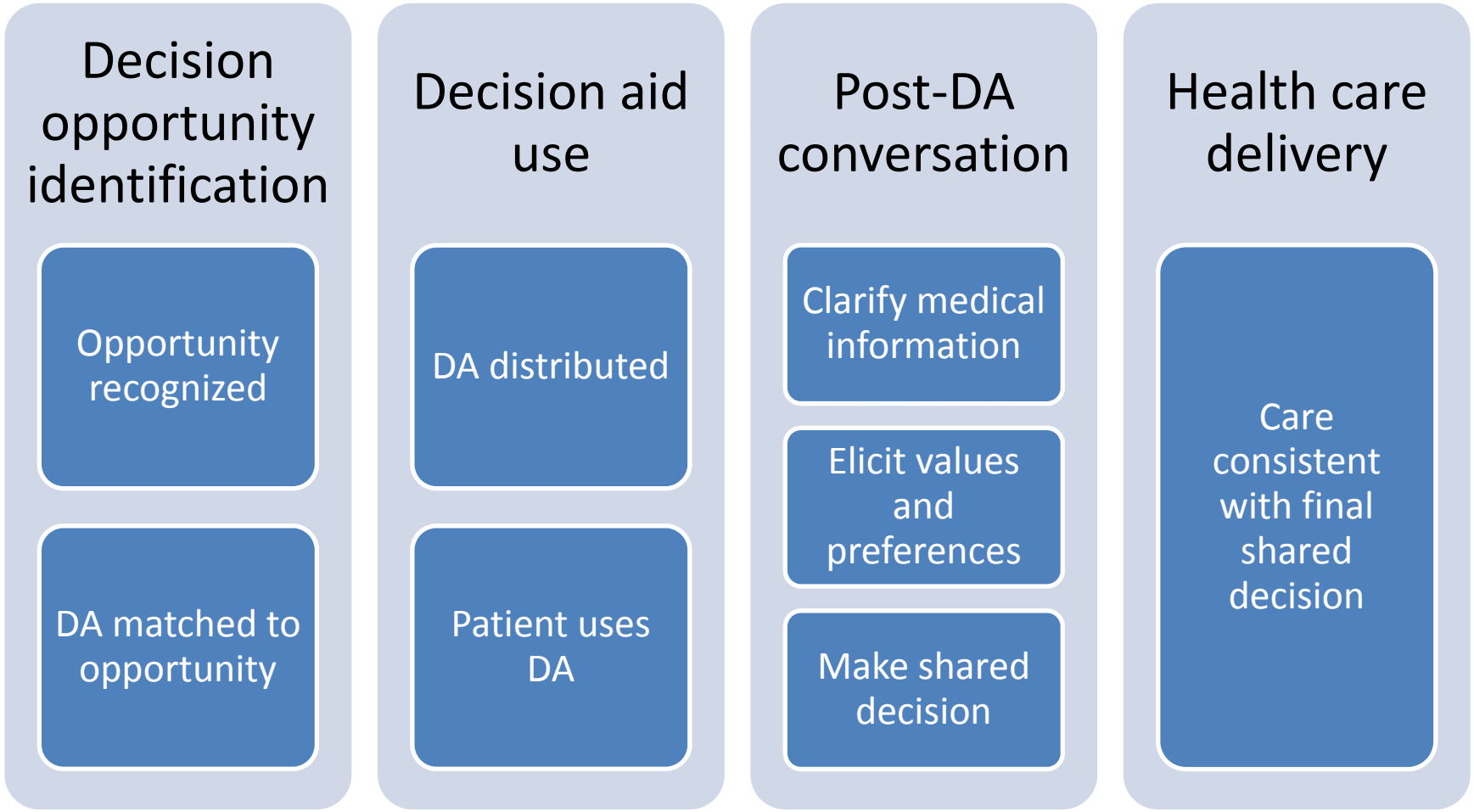
We Evaluated A Demonstration Of Shared Decision Making

- 8 sites, 34 primary care practices
- Convened and funded by the Informed Medical Decisions Foundation
  - Free decision aids
  - Technical assistance
  - Learning collaborative
- Qualitative evaluation at 18 months

Key Steps Of Shared Decision Making Based On Decision Aids



Barriers To Implementation

- Overworked physicians do not recognize decision opportunities and distribute decision aids reliably
- Insufficient provider training
  - Recognizing decision opportunities and having post-decision aid conversations are skills providers must learn
- Inadequate clinical information systems
  - Not able to track the full sequence of steps involved in shared decision making

Solutions Sites Employed

- Automatic triggers for decision aid distribution
  - Trigger on patient age and gender (for screening)
  - Trigger on specialist referrals (for surgical procedures)
- Engage team members other than physicians

Measuring Implementation

- **Process measures should capture all steps of shared decision making**
  - **"All-or-none" measures may be appropriate**
- **Measures of decision quality**
  - **In the end, was care consistent with the patient's values and preferences?**

Group Health Demonstration

Lessons Learned About The Role Of Leadership And Culture Change

Benjamin Moulton
Senior Legal Advisor
Informed Medical Decisions Foundation

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

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Group Health Demonstration

The Washington State legislation is significant in several respects:

1) **Shared decision making and the potential benefit of using decision aids are formally acknowledged for the first time by a state legislature;**
2) **Washington undertakes a demonstration project to evaluate the implications of incorporating SDM and the use of decision aids into everyday practice; and**
3) **Bill provides legal protection to physicians who choose to engage in Shared Decision Making with their patients.**
4) **Non Funded Mandate- Voluntary participation**

Group Health Demonstration

- 660,000 patients- Integrated Consumer governed health system
- Distributed 27,000 PtDA's over two years
- Selected 12 Preference Sensitive Conditions
- Demonstrated that they could integrate distribution and use into clinical practice
- Encouraged by favorable satisfaction surveys
- Found decision aids and SDM economically and clinically feasible
- Intent to broaden implementation to all preference sensitive conditions across GH system and network

Lessons Learned

- Patients need to be invited into conversation- More than 90% of responding patients strongly supported and the more that clinicians committed to integrating the more comfortable patients felt in voicing their opinions
- Addressing unwarranted variation- Patient engagement to identify treatment choices that are the result of patient preferences and values
- Effective integration requires leadership at all levels- champions lead culture change
- Constant evaluation and iterative improvement is necessary
- SDM should be embedded in physician training and culture

Health Policy Reasons For Adoption Of SDM On Large Scale

- Ethical imperative to do the right thing
- Perfected Informed Consent-aligning preferences, values and lifestyle with individual's clinical decision
- Bridging health disparities
- Conservative utilization of surgical interventions

Decision Aids: When Nudging Is More Ethical Than Balanced, Non-Directive Content

Jennifer Blumenthal-Barby, PhD

Baylor College of Medicine

Center for Medical Ethics & Health Policy

Co-Authors: Scott Cantor PhD, Heidi Russell MD PhD, Aanand Naik MD, Robert Volk PhD

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Our Challenge

- **IPDAS Collaboration sets standards for development and evaluation of decision aids**
- **Chapter I: Balanced Presentation of Options**
  - **"*Complete, unbiased,* and *neutral* presentation of the relevant options and the information about these options-in content, in format and in display-in a way that enables individuals to process this information without bias."**

➢ **Unbiased, neutral presentation of options may not be possible (framing effects)**

➢ **May not be desirable—may be situations where one option should be highlighted, or patients nudged to consider it more**

Our Three Situations

- **One treatment option is often not considered by patients or offered to them, despite clinical evidence that it is a viable option.**
  - ***Example: Active surveillance for certain forms of early stage prostate cancer.***
- **A treatment or prevention decision is strongly supported by clinical evidence as being high benefit and low risk.**
  - ***Example: Colorectal screening for ages 50-70***
- **The patient's habits, concerns, preferences or goals point toward a particular option.**
  - ***Example: Oral vs. subcutaneous anticoagulant for deep vein thrombosis***

Possible Nudges

- Normative messages in decision aid to support active surveillance as reasonable option, making risks of surgery and radiation more salient.
- Remove “no screening” option for colorectal screening, instead just listing types of screening.
- Your values/habits clarification exercise suggests….

Concerns And Justification

- Risk to credibility of decision aids? Nudge or shove? Decision aids vs. health education intervention?
- Credibility boosted by developers who counter existing biases, inconsistent practice patterns, and promote patient health-related interests.
- Influence as a continuum (appeals to norms, values, framing information←→concealment of options, deception, threats); evidence-based.
- Blurring distinction but decision aid recognizes there is a choice to be made.

- Careful ethical consideration and challenging, but cannot turn blind eye to perils of strict adherence to neutrality.

Shared Decision Making: Examining Key Elements And Barriers To Adoption Into Routine Clinical Practice

France Légaré, MD PhD
Canada Research Chair in Implementation of Shared Decision Making in Primary Care
Holly O. Witteman, PhD, Assistant Professor
Department of Family Medicine and Emergency Medicine, Université Laval, Québec City, Québec, Canada
Research Center of CHU de Québec, Québec City, Québec, Canada

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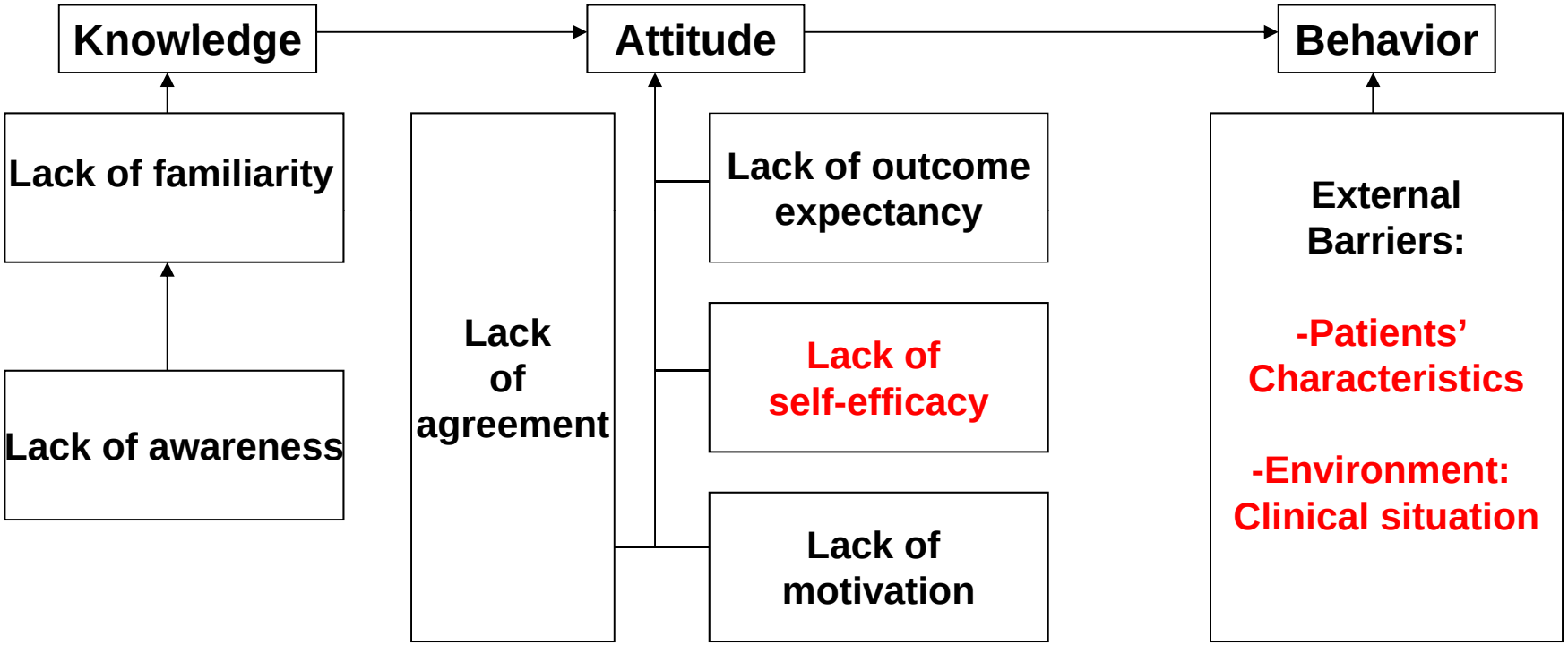
The Clinical Consultation

- **Key opportunity** to **engage patients** through the process of shared decision making
- Where **opportunities** and **challenges** for **expanding** the use of shared decision making across the health care continuum can be identified

Shared Decision Making

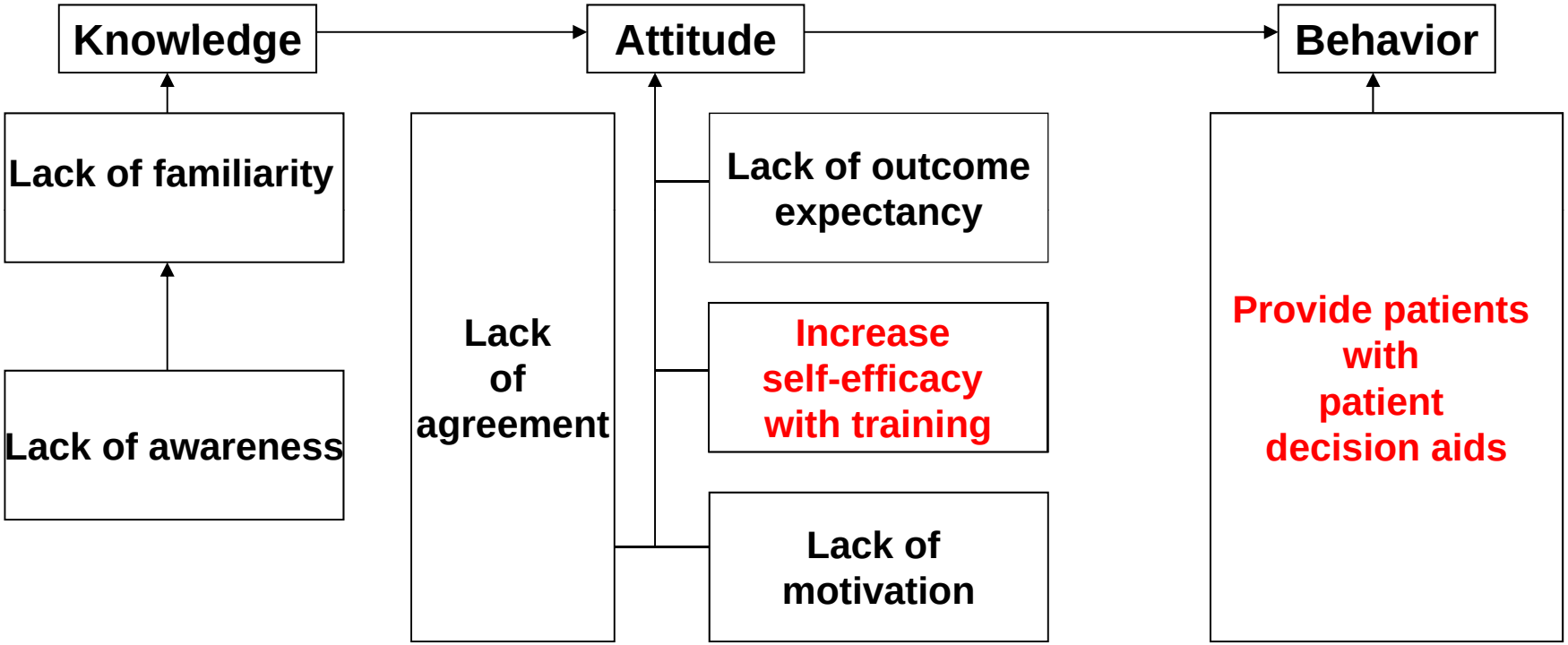
- **Interpersonal** and **interdependent** process
- Recognizes that a **decision is required**
- Highlights best available evidence about **risks** and **benefits** of each option
- Takes into account both the provider's **guidance** and the patient's **values** and **preferences** (patient specific)

Barriers To Shared Decision Making



Adapted from Cabana & al. Barriers to CPGs JAMA, 1999

Implementing Shared Decision Making



Cochrane systematic reviews
- Stacey et al. 2011
- Légaré et al. 2010

Patient Engagement, Costs And Insurance

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Engaging Patients With Quality And Cost Information

Jill Yegian, PhD
American Institutes for Research
February 6, 2013

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Key Takeaways

- Consumer lens on quality and cost information is important and distinct
- Evidence on effective presentation of information is inconsistently applied
- Distinctive features of cost and quality information point to collaboration and experimentation

Contact And Co-Authors

Jill M. Yegian, PhD

jyegian@air.org

www.air.org

Co-Authors:

- **Pam Dardess, American Institutes for Research**
- **Maribeth Shannon, California HealthCare Foundation**
- **Kristin Carman, American Institutes for Research**

Patients With Lower Activation Associated With Higher Costs;

Delivery Systems Should Know Their Patients' 'Scores'

Judith Hibbard, DrPH
Jessica Greene, PhD
Valerie Overton, DNP

Supported by The Commonwealth Fund

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Study Approach

Goal: To examine the relationship between patient activation level in 2010 and costs in 2010 & 2011

- Setting: Fairview Health Services, MN
- Data: PAM from electronic medical record for 33,163 patients & billed costs from administrative data
- Analysis: Used one-part OLS regression models to predict costs at each activation level, adjusting for demographic factors and health risk

Ratio Of Predicted Costs By Patient Activation Level

Patient Activation Level	Ratio of Predicted Costs to Level 4 PAM 2010	Ratio of Predicted Costs to Level 4 PAM 2011
1 (Lowest)	**1.08**	**1.21**
2	1.03	1.05
3	0.99	0.97
4 (Highest)	1.00	1.00

Ratios Of Predicted Costs By Condition

Patients with Chronic Conditions	Ratio of 2010 Predicted Costs For PAM 1 Compared with Level 4 PAM
Asthma	**1.21**
Diabetes	1.07
Hypertension	**1.14**
Hyperlipidemia	**1.12**

Conclusion

- Patients with low activation had significantly higher billed costs than those with higher activation levels
  - Increasing patient activation may be a pathway to controlling health care costs, as well as improving quality

Focus Groups Highlight That Patients Object to Clinicians Focusing on Costs

Marion Danis, MD

For Roseanna Sommers, Susan Door Goold, Elizabeth McGlynn, Steven Pearson

HealthAffairs

Disclaimer

- **The views expressed here are those of the authors and do not necessarily reflect the policies of the National Institutes of Health, the US Department of Health and Human Services, Kaiser Permanente, or RAND.**

Background

- Having clinicians and patients consider costs when making medical decisions has been proposed as a way to contain health care spending
- Explicit discussion of costs has advantages
  - Procedurally fairer than implicit forms of cost containment
  - Allows patients to have more input in decisions that affect their own out-of-pocket costs

Methods

- We conducted 22 focus groups of people with health insurance
  - to examine their attitudes towards discussing their own costs and insurer costs during the clinical encounter
  - ½ below 300% of the poverty threshold
  - ¼ Latino, 1/3 African American
  - ¼ had one or more chronic illnesses

Scenarios

- Physicians talked to about diagnostic and treatment options that differ marginally in effectiveness but varied substantially in either out-of-pocket or insurer costs
- Example: 3 months with worst headache to be evaluated with CT scan or MRI

Results

- **Four fifths of comments reflected unwillingness to consider costs**
  - **Wanting only the best**
    - **"When it comes to you're your health, there really is no value on it.**
  - **Unaccustomed and reluctant to make trade-offs between health and money**
    - **"Doctors shouldn't leave it up to you. He's the doctor.**

Results

- Lack of awareness that that personal finances can have a profound effect on health status
- Wariness about being considered too poor to receive good care

Results Regarding Insurer Costs

- Familiarity with the national problem of national health care costs without a sense of responsibility for the problem
- Skepticism about the need for cost-conscious decisions rather than elimination of waste
- Antagonism toward insurers and government

Implications

- Getting patients to focus on costs in medical decisions will require a shift in public attitudes
- This will require
  - Research in patient education
  - Training of clinicians to discuss costs
  - Reducing trepidation about cost containment in the public arena
  - Learning from precedents in other countries and other policy arenas

The Affordable Care Act's Plan For Consumer Assistance With Insurance Moves States Forward But Remains A Work In Progress

Rachel Grob, Ph.D
Mark Schlesinger, Ph.D
Sarah Davis, JD, MPA
Deborah Cohen
Josh Lapps, M.A.

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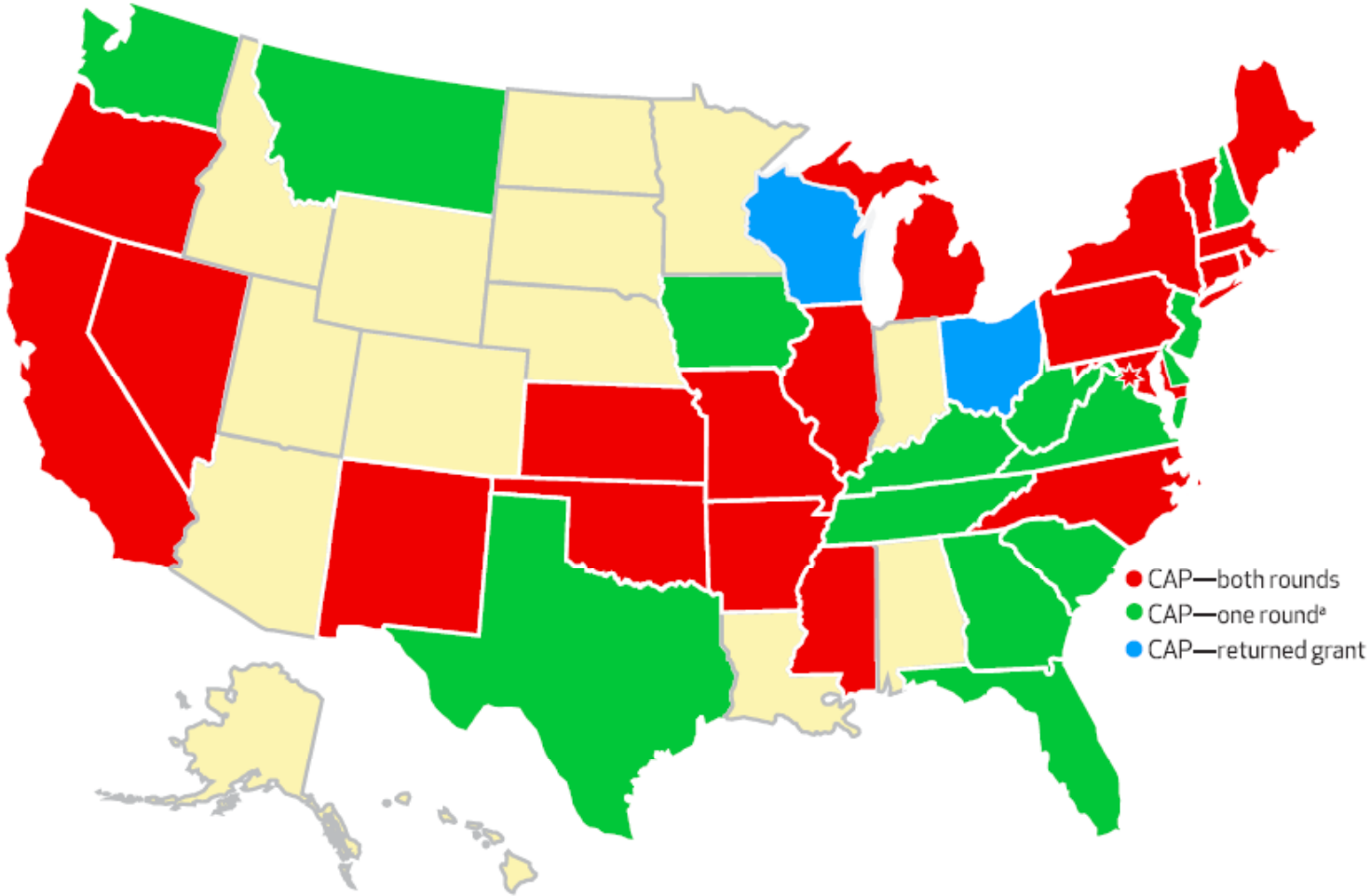
What Are CAPs And How Do They Relate To Patient Engagement?

- Origins
- Historical Functions
- Transformation Under the PPACA

Geographic Distribution Of CAPs Grants (2010-12)



Defining Free And Vigorous Advocacy

EXHIBIT 2

Dimensions Of Free And Vigorous Advocacy Evident In State Consumer Assistance Programs

Major dimension of advocacy	Specific facets of that dimension
Accompanying consumers	Reaching consumers early in each problematic episode No wrong door: coordination across multiple entry portals Sticking with the client over time
Embracing consumers' perspective	Helping answer all questions, even outside of jurisdiction Acknowledging confusion; rebuilding hope Representing consumers' best interests
Empowering consumers	Empathic listening Serving as trusted interpreter of insurance practices Building consumer capacity for future self-advocacy

Enhancing Future Potential: Proof Of Concept

- State Contexts Conducive to Transformation
- Federal Resources to Sustain Transformation
- Spillover to Other Patient Empowerment

Do I Look Like An Idiot?

Why We Take A Systems Approach To Health Literacy

Linda Harris, PhD
Senior Health Communication and ehealth Advisor, Office of Disease Prevention and Health Promotion, US Department of Health and Human Services
on behalf of my co-authors, Howard Koh, Cindy Brach and Michael Parchman

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A Surprisingly Productive Interaction

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The Care Model- A Systems Approach to Quality Improvement

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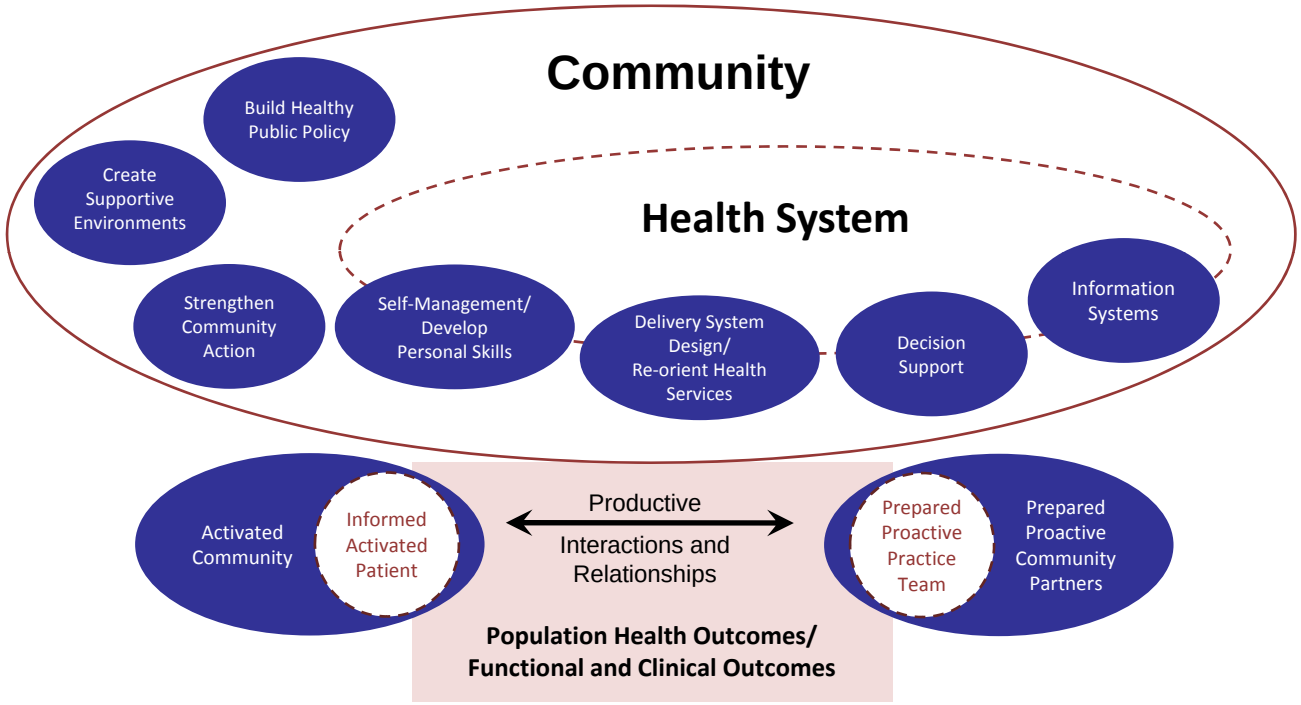

Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)

Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). "Does the Chronic Care Model also serve as a template for improving prevention?" *The Millbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

Health Literacy Universal Precautions

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- Health literacy – the ability to obtain, process, communicate and understand basic health information.

- Universal Precautions Toolkit-Across-the-board strategies instituted to improve health literacy for all patients

- The Health Literate Care Model
  - incorporates health literacy improving strategies within each of the components and
  - uses patient feedback to measure the organizations' progress toward continually improving strategies for improving informed engagement

In Summary

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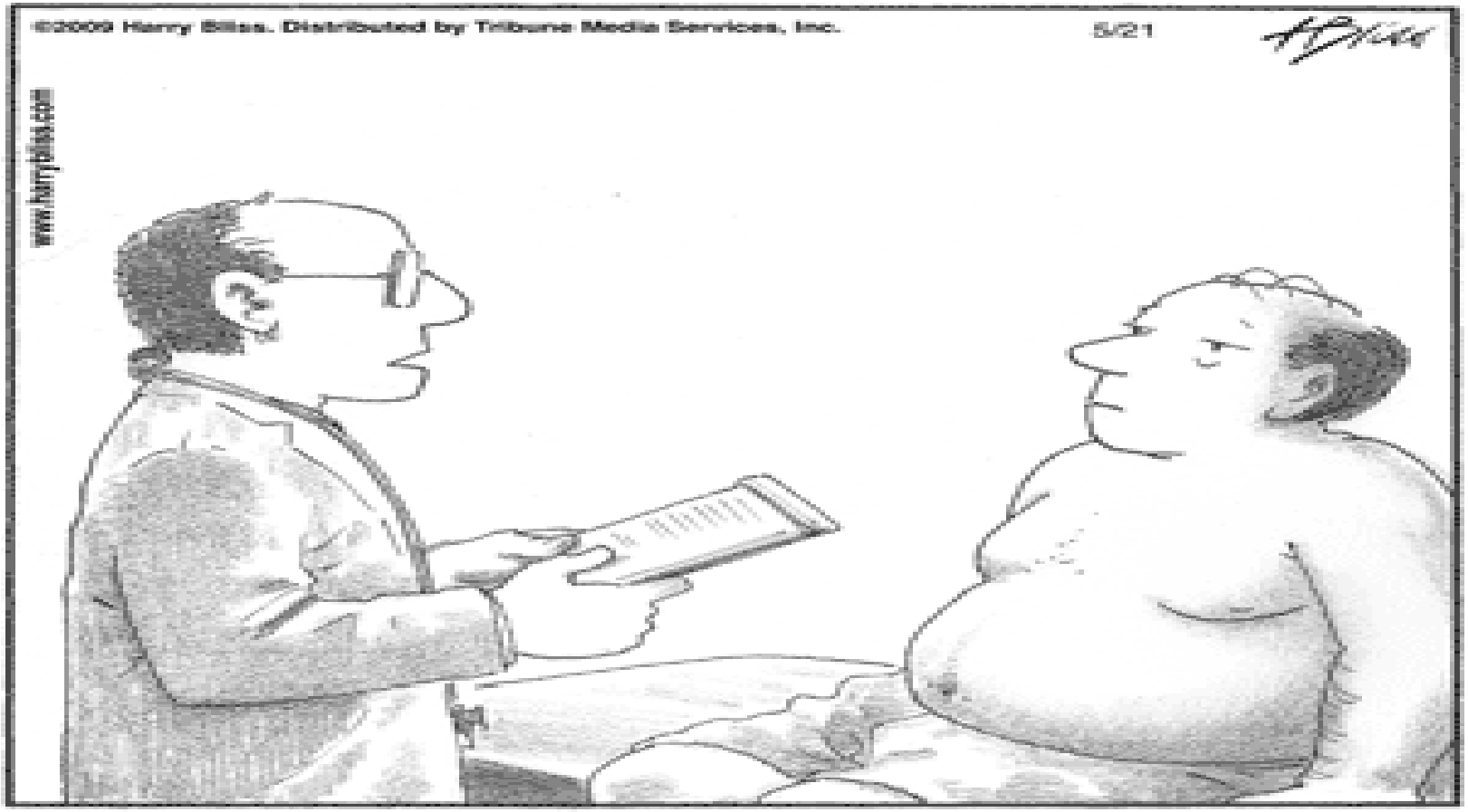

"Well, yes, I suppose I could explain the test results in 'plain English' — but then you'd know how sick you are."

How Patient-Centered Medical Homes Involve Patients/Families In Quality Improvement

Esther Han, *Sarah Hudson Scholle*
Suzanne Morton, Christine Bechtel,
Rodger Kessler

Special thanks to PCPCC, AAFP Research Network , and The Commonwealth Fund for supporting this work

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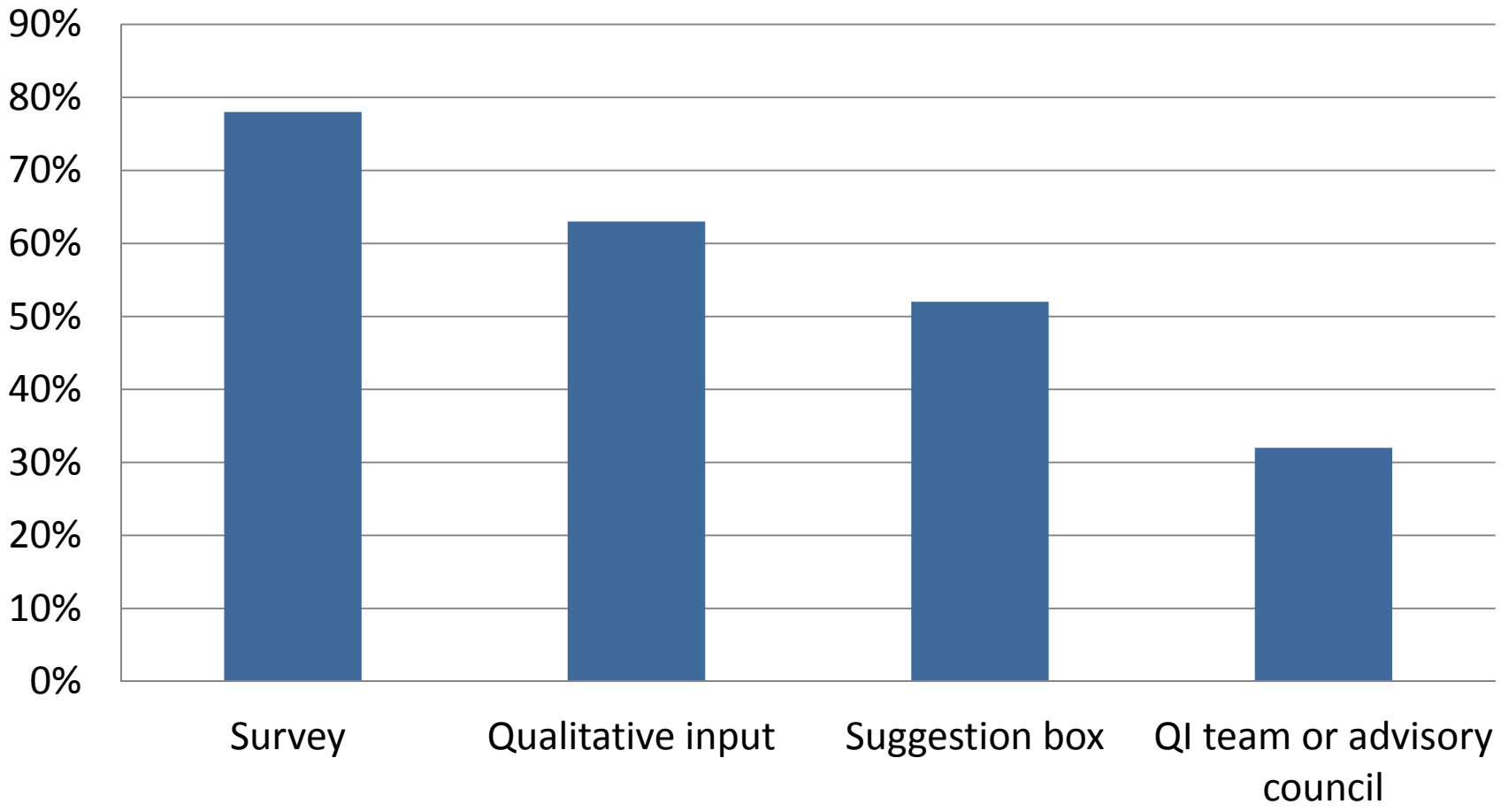
How Do Practices Involve Patients And Families In Quality Improvement?



Committed Practices Overcome Obstacles And Fear

Low Involvement

"Patients have no understanding of what [it takes] to run an office. . . . of what goes into seeing a patient."

"If you ask, there's the implication that you'll do something with the answer and that you'll try to give them what they say they want."

High Involvement

"To be more effective, you have to figure out what patients want out of you."

"[Patients] need to be partners in their own care. . . . We need to give them that respect and then begin to arm them with ways to take care of themselves."

What Will It Take

- *Culture shift*
- Examples of success
- Help in implementation
- Public reporting on patient experiences
- Financial incentives

Increasing Patient/Family Involvement

- **NCQA's Response**
  - **Increased emphasis in PCMH 2011 standards**
  - **Distinction in Patient Experiences**
- **Providers**
  - **Commitment to partnership**
- **Sponsors and Policymakers**
  - **Keep expectations high**
  - **Provide technical assistance**
  - **Reward practices for involving patients and families**

A National Action Plan To Support Consumer Engagement Via E-Health

Lygeia Ricciardi, Ed.M.
Director, Office of Consumer eHealth
Office of the National Coordinator for Health IT

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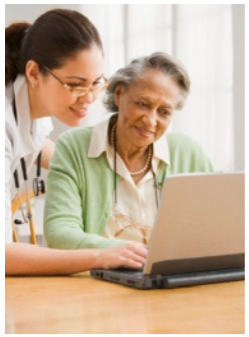
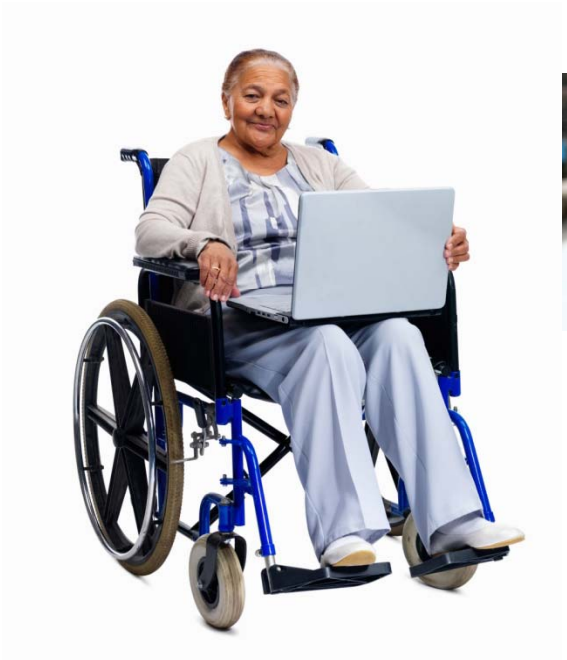
How Can Consumers Engage Through eHealth?

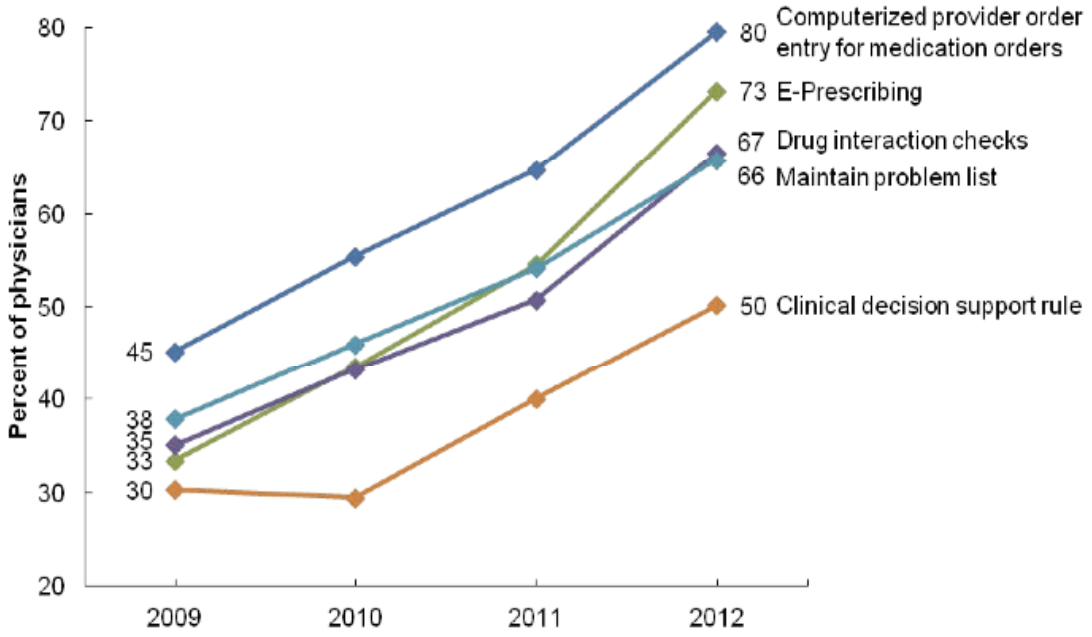
- Communicate & coordinate with providers
- Self manage health & wellness
- Engagement applies across demographic groups





Why Now?

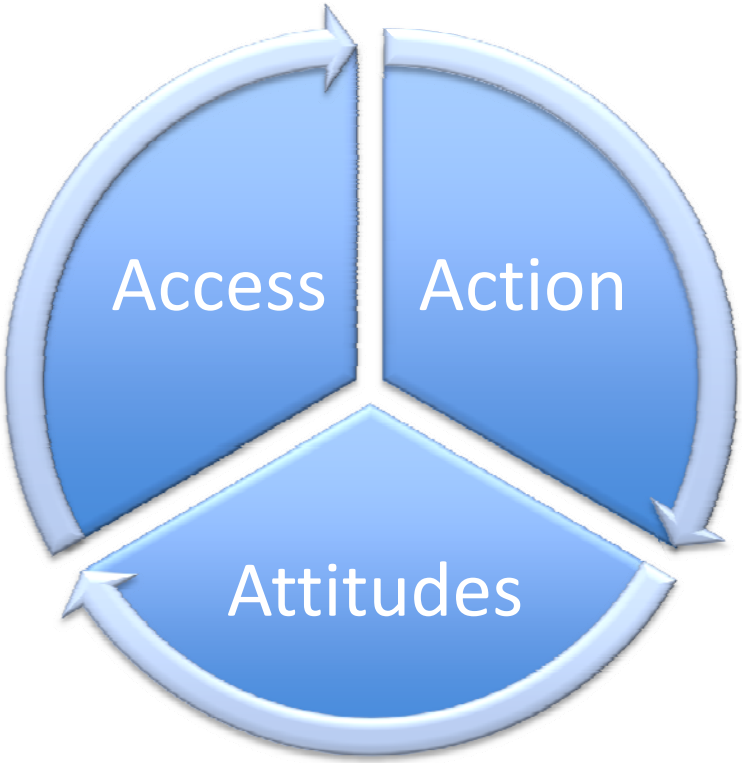
- Health IT adoption is up
- Technological revolution
- Financial responsibility for consumers is growing
- Consumer demand



Source: ONC analysis of national surveys

The 3 As Approach

Increase consumer Access to health information



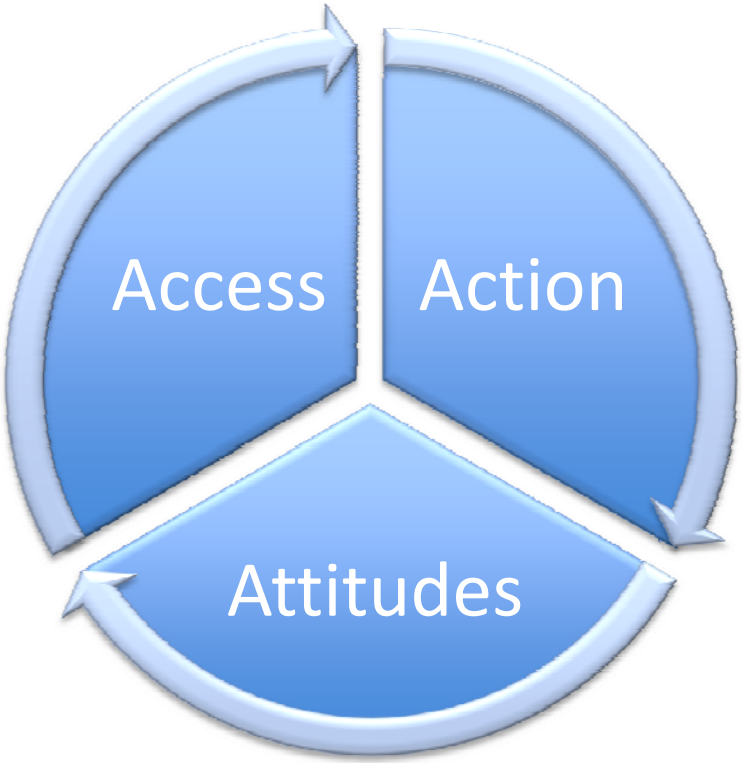
Enable consumers to take Action with their information

Shift Attitudes to support patient-provider partnership

The 3 As Approach

Meaningful Use incentives for providers & Blue Button Pledge for providers & payers

Blue Button Pledge
To Empower Individuals to Be Partners in Their Health Through Health IT



Implementation guide & challenges for developers; tools for consumers

Animation, crowd-sourced videos, stories & tools for consumers

HealthIT.gov

Choice Architecture Is A Better Strategy Than Engaging Patients To Spur Behavior Change

Bob Nease, PhD

Chief Scientist, Express Scripts

http://Lab.Express-Scripts.com

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Human brain processes
10 million bits per second

Conscious mind processes
50 bits per second

We are wired for inattention & inertia

Sources: Koch et al , Current Biol, 2006; Norretranders, The User Illusion, 1999.

Choice Architecture

- **Opt Out** – default to preferred choice
- **Active Choice** – required to state choice
- **Precommitment** – choose in advance

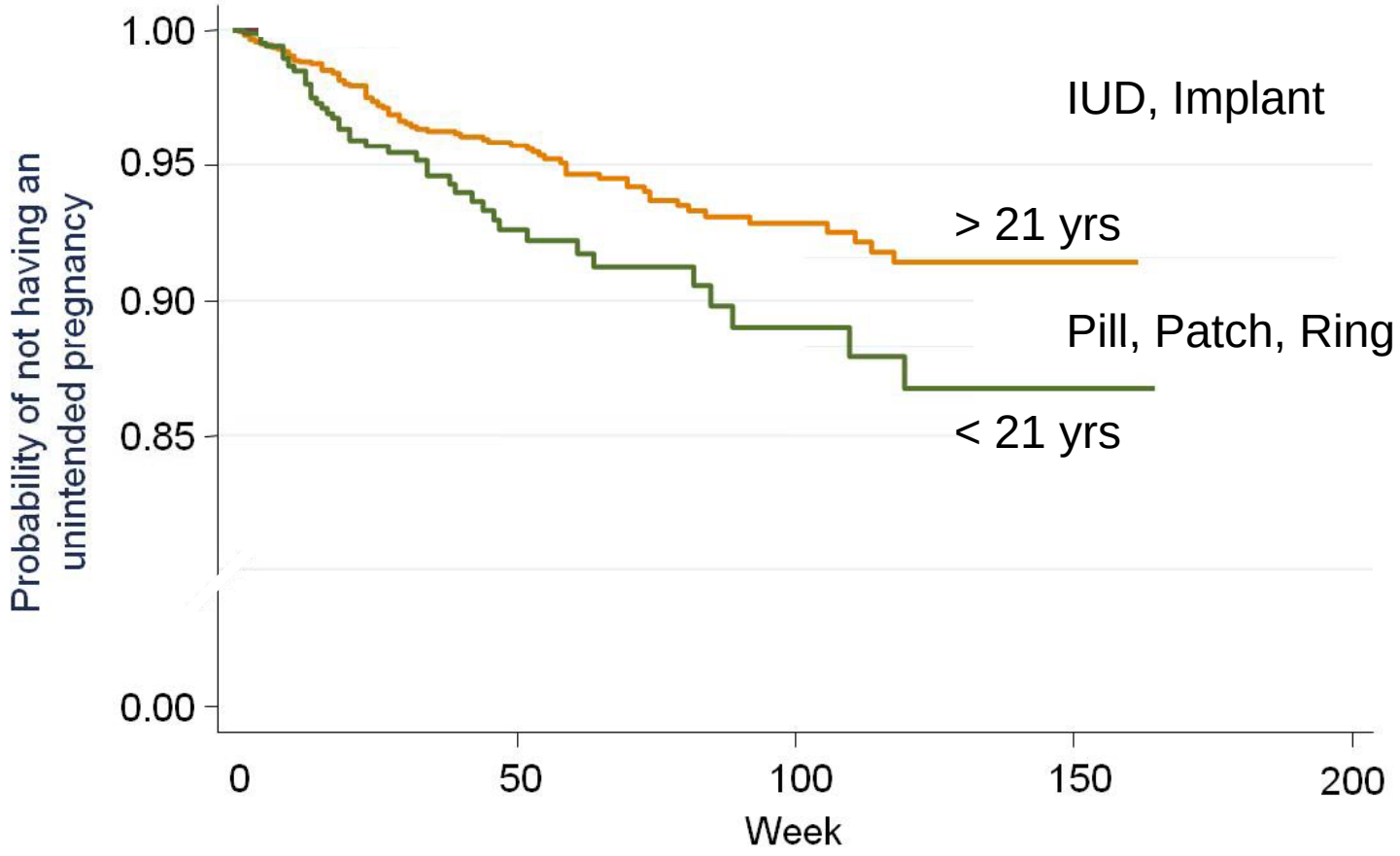
Choice architecture admits – and even leverages – disengagement

Choice Architecture Works

		Fraction exhibiting preferred behavior
Opt out (N = 9,450)	Generic vs. Brand	93.1 - 98.5%
Precommitment (N = 340,683)	Generic vs. Brand	52.8%
Active choice (N = 40,769)	Mail vs. Retail	39.6%

Ongoing behaviors are more challenging

Precommitment In Contraception Leads To Desired Outcome



Source: Winner et al. NEJM, 2012.

Summary

- Human attention is scarce & fleeting
- Patient engagement a tall order
- Choice architecture effectively addresses inattention & inertia
- Proven to work in pharmacy
- Addressing nonadherence can reduce costs, improve health outcomes

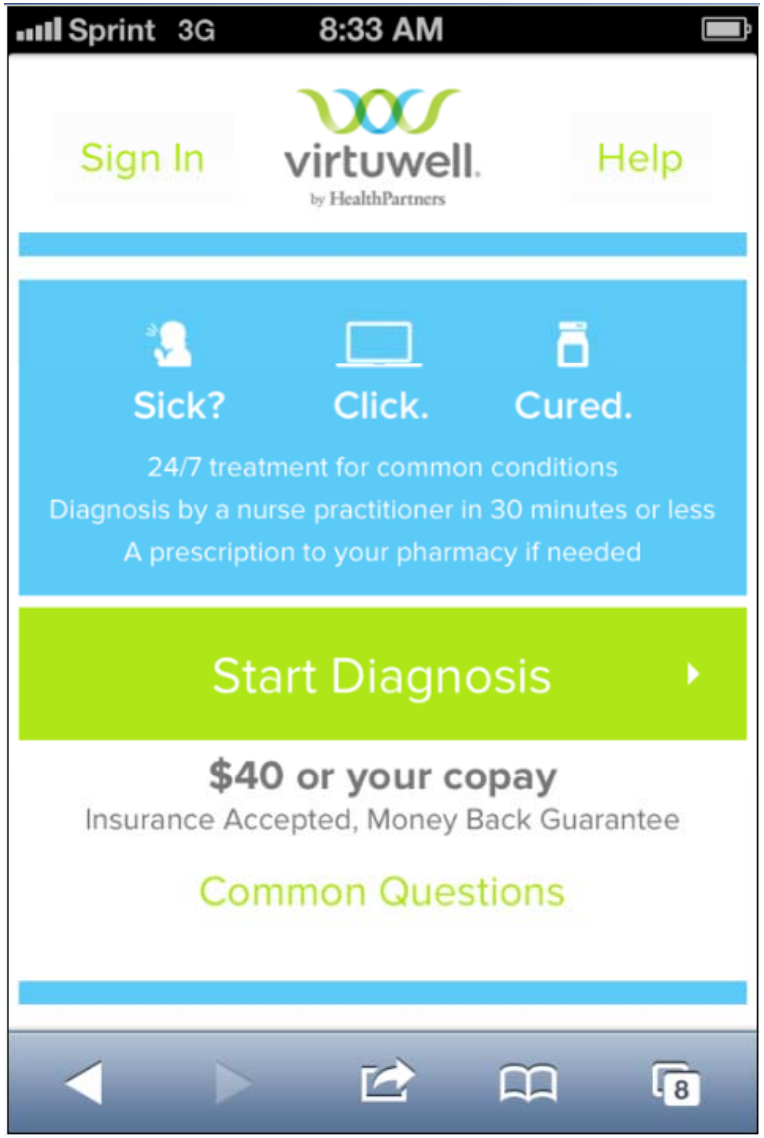
For more healthcare insights, visit http://Lab.Express-Scripts.com

HealthPartners' Online Clinic For Simple Conditions Delivers Savings Of $88 Per Episode And High Patient Approval

Kevin Palattao

Vice President HealthPartners

HealthAffairs


Sprint 3G
8:33 AM
Sign In
virtuwell
by HealthPartners
Help
Sick?
Click.
Cured.
24/7 treatment for common conditions
Diagnosis by a nurse practitioner in 30 minutes or less
A prescription to your pharmacy if needed
Start Diagnosis
$40 or your copay
Insurance Accepted, Money Back Guarantee
Common Questions
8

Summary Results

- **$88/episode avg. lower cost**
- **99% say it's simple to use**
- **98% would recommend**
- **95% say saves 2.5 hours**
- **94.2% antibiotic compliant**

Patient Engagement And End Of Life

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Default Options In Advance Directives Influence How Patients Set Goals For End-of-life Care

Scott D. Halpern, M.D., Ph.D.

Assistant Professor of Medicine, Epidemiology, and Medical Ethics & Health Policy

Director, Fostering Improvement in End-of-Life Decision Science (FIELDS) program

Deputy Director, Center for Health Incentives and Behavioral Economics (CHIBE)

University of Pennsylvania

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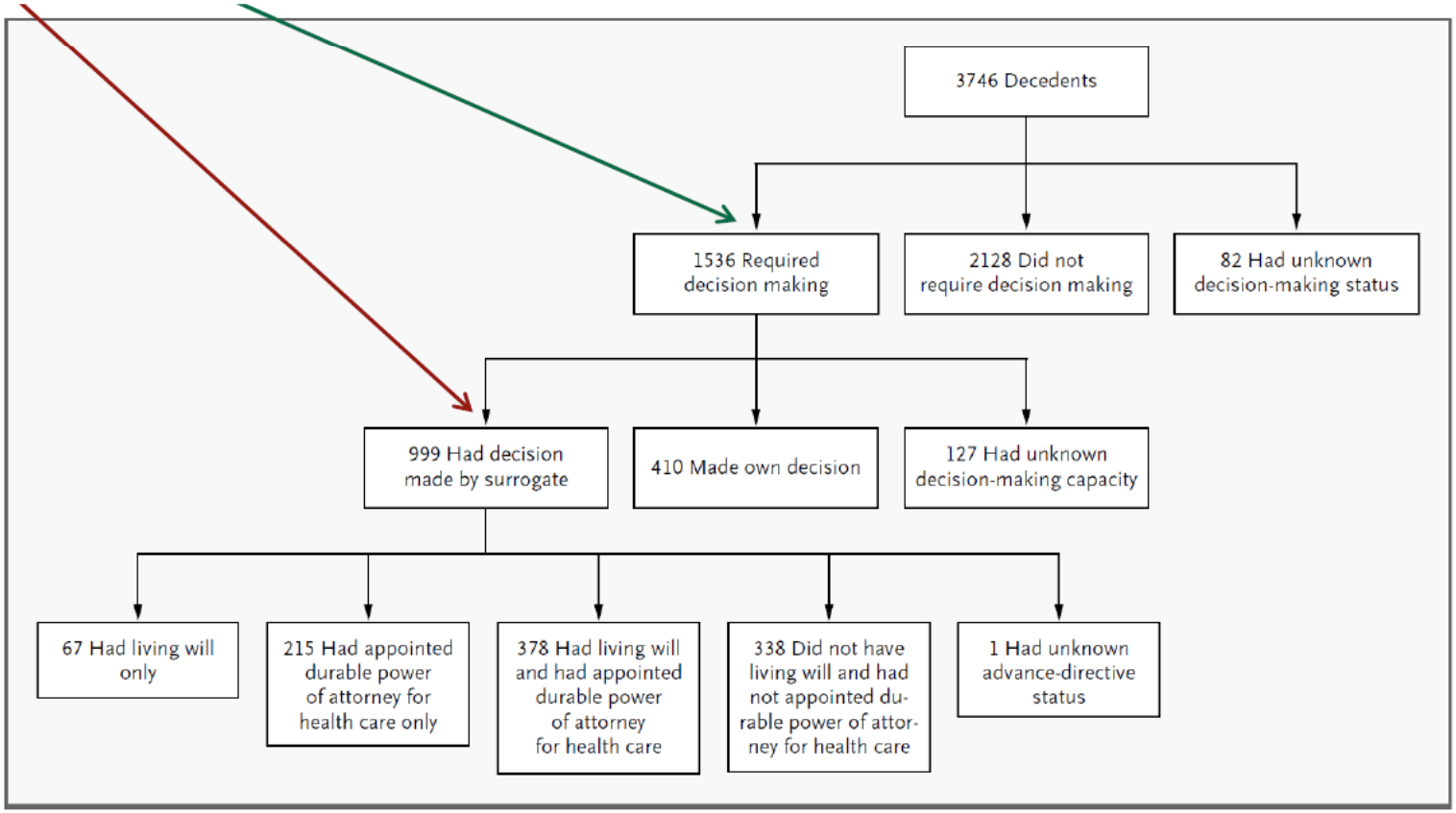
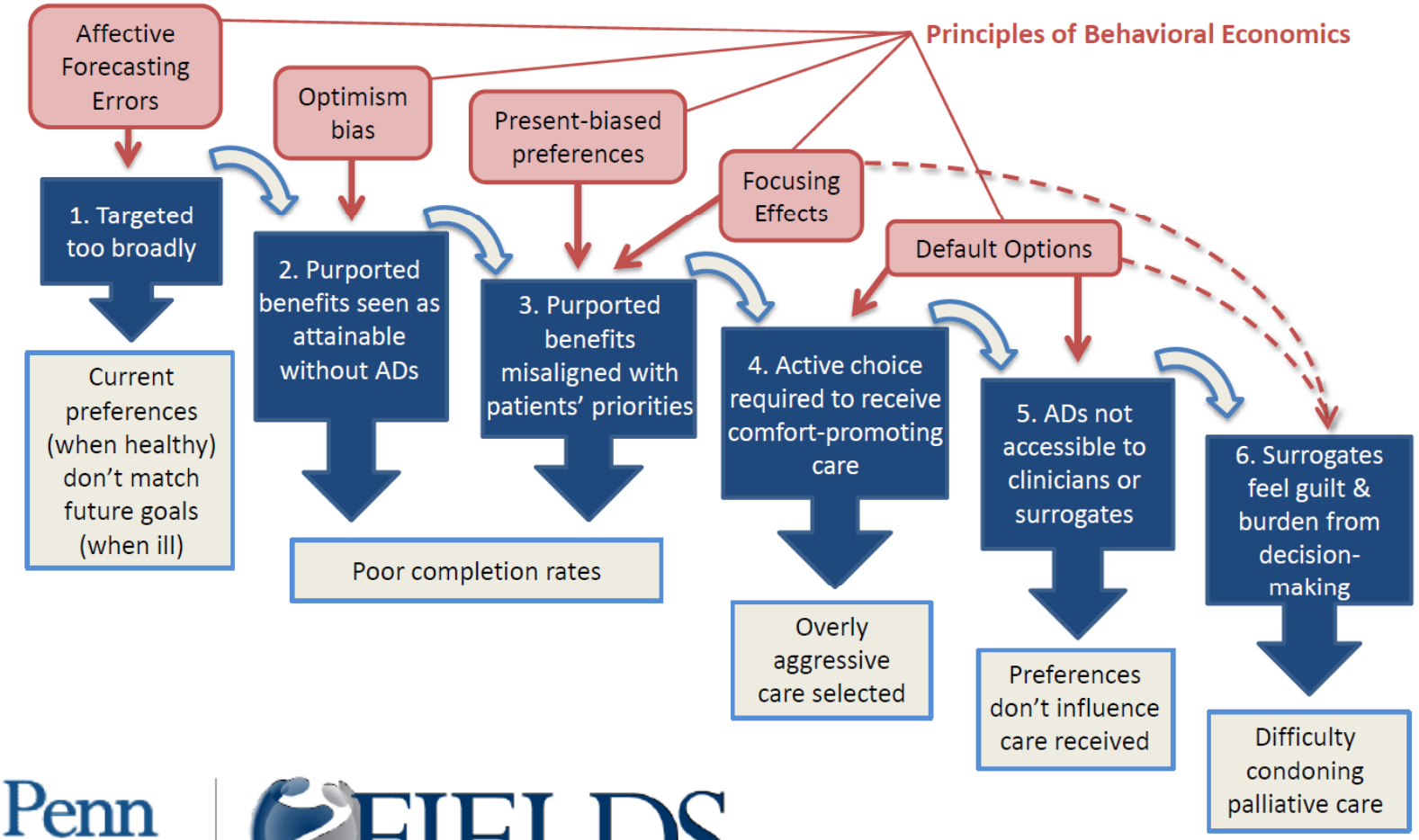
The Promise Of Advance Directives

- 43% of older Americans need healthcare decisions made near death
- 70% of these patients can't participate in decisions when needed



Silveira MJ, et al. N Engl J Med 2010; 362: 1211-8.

The 'Failure Curve' Of Implementing ADs



Penn Medicine | FIELDS Fostering Improvement in End-of-Life Decision Science

Halpern SD. Shaping end-of-life care. Sem Respir Crit Care Med 2012; 33:393-400.

RCT Of Default Options In Real Ads

- 132 patients with advanced emphysema, lung cancer, and other terminal diseases recruited from Penn outpatient clinics
- 95 (72%) completed ADs
- After debriefing, no patients changed their specific choices

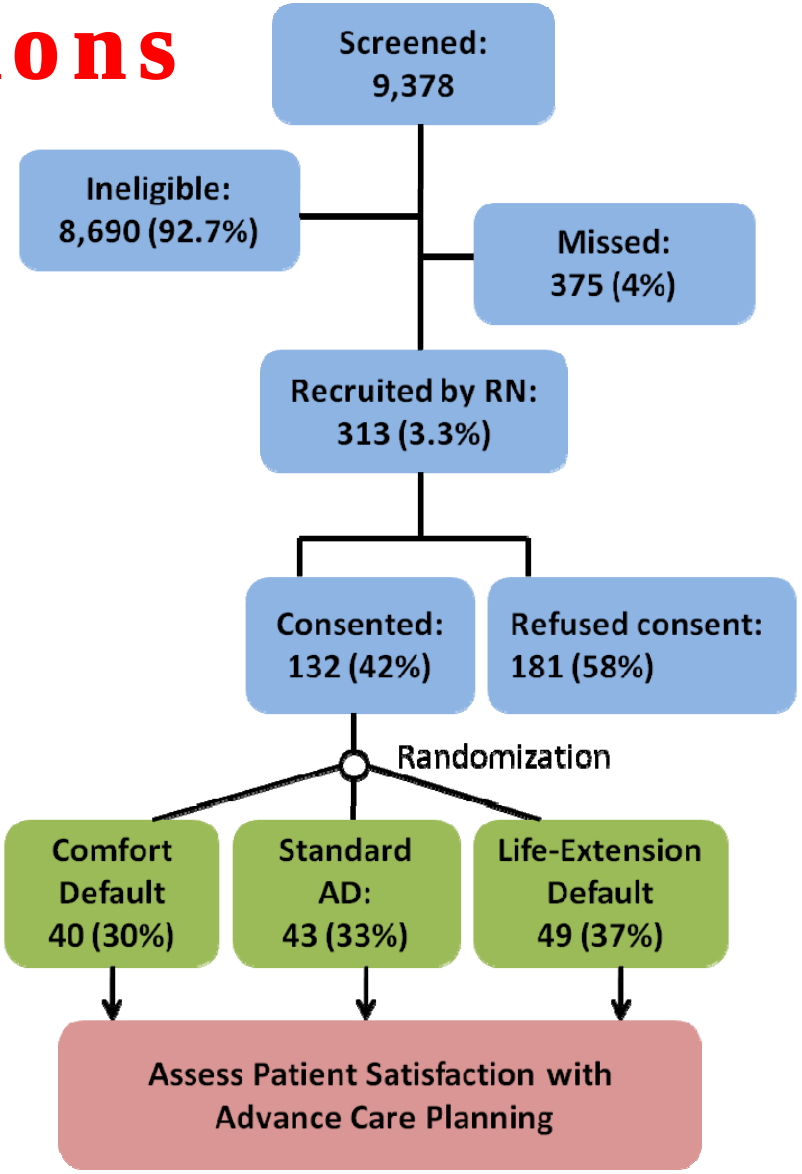


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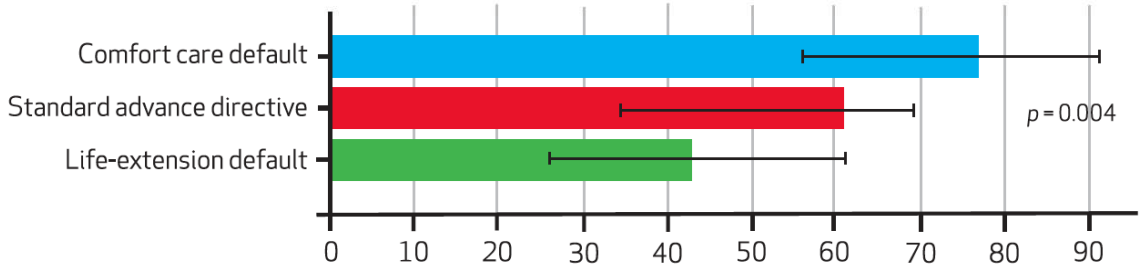
EXHIBIT 2

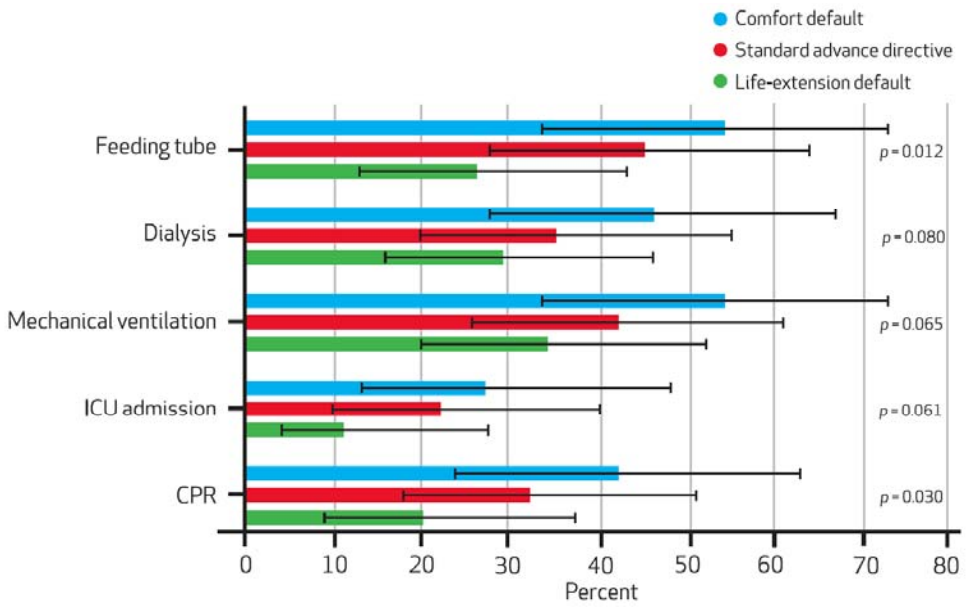
Percentage Of Patients Choosing A Comfort-Oriented Goal Of Care (Per Protocol Population)



No differences among arms in patients' satisfaction with advance care planning 2 months later (all p > 0.4)

EXHIBIT 3

Percentage Of Patients Choosing To Forgo Each Intervention, By Type Of Advance Directive (Per Protocol Population)



Conclusions

- Default options strongly influence the care patients choose near the ends of their lives, even after patients are alerted to the default
- Seriously ill patients are content to be nudged towards end-of-life-care choices, suggesting that many lack deep-seated “preferences” for such care
- Future studies are needed to determine how using default options in advance directives influences clinical, economic, and patient- and surrogate-reported outcomes

Penn Medicine | FIELDS Fostering Improvement in End-of-Life Decision Science

Engaging Patients And Their Loved Ones In The Ultimate Conversation

Maureen Bisognano
President and CEO
Institute for Healthcare Improvement

Ellen Goodman
Co-founder and Director
The Conversation Project

HealthAffairs

An Alarming Disconnect

- 70 percent of Americans want to die at home…but 70 percent die in institutional settings[1]
- 80 percent of Californians want to speak to a doctor about end-of-life wishes…but only 7 percent have done so[2]
- 82 percent of Californians say it's important to put their wishes in writing…but only 23 percent have done so[2]

[1]CDC. Worktable 309: deaths by place of death, age, race, and sex: United States, 2005.
[2]California HealthCare Foundation. Final chapter: Californians' attitudes and experiences with death and dying. CHCF, 2012.

Two Complementary Initiatives

the conversation project

- Everyone's end-of-life wishes will be *expressed* and *respected*
- Every one has a story to tell
- The conversations are personal, not medical
- The power of storytelling

http://theconversationproject.org/

conversation ready

- Develop a culture of shared decision making with patients
- Improve processes to reliably prompt, store, and access end-of-life care wishes

http://www.ihi.org/offerings/Initiatives/ConversationProject/Pages/ConversationReady.aspx

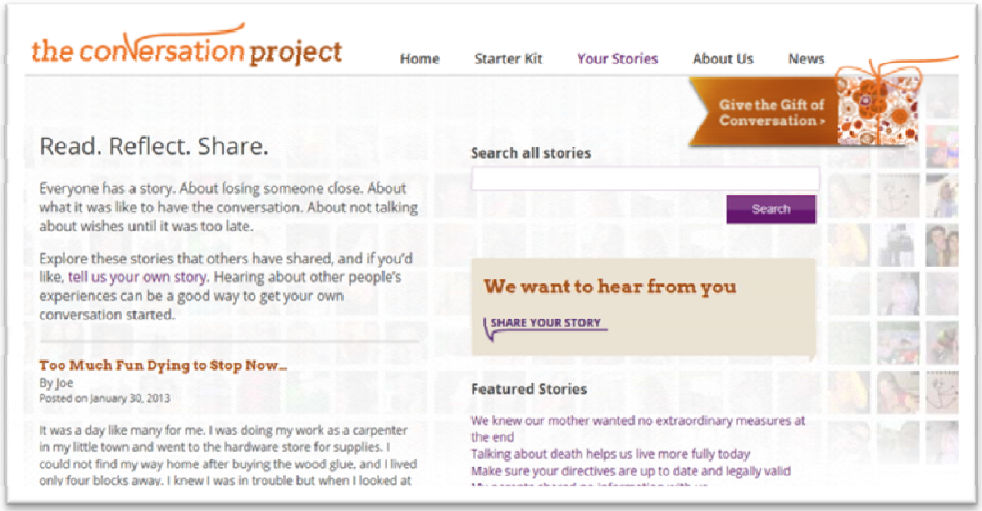
The Conversation Project

- A grassroots movement to encourage everyone to have conversations about end-of-life wishes with loved ones “at the kitchen table”
- Bringing about change “from the outside in”
- Leveraging media, including social media, to bring messages and tools to all
- Targeting specific geographic regions and segments of the population

the conversation project

Early Enthusiasm

- **Over 68,000 visits to website (theconversationproject.org)**



- **Over 23,000 downloads of the Conversation Starter Kit (also available in Spanish)**

Conversation Ready

- IHI initiative: 10 Pioneer organizations committed to being "conversation ready" within one year
- Requires a new perspective – moving beyond the current "rescue culture" of US health care
- Leveraging the lessons of exemplar organizations such as Gundersen-Lutheran in La Crosse, WI, and Dana-Farber Cancer Institute in Boston, MA

conversation ready

Thank You!

- **Maureen Bisognano**
  President and CEO
  IHI
  mbisognano@ihi.org
- **Ellen Goodman**
  Co-Founder and Director
  The Conversation Project
  egoodman@ihi.org

Institute *for* Healthcare Improvement

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