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Association



# Engaging Health Care Users: *A Framework for Healthy Individuals and Communities*



  
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**pursuit of excellence™**  
*Accelerating Performance Improvement*



A Report of the AHA Committee on Research:

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## Executive Summary

The mission statement of virtually every hospital in the United States is to improve the health of individuals and communities. This is evident in the manifestation of the Triple Aim for the U.S. health care system, a framework developed by the Institute for Healthcare Improvement. This framework includes three dimensions: improve the health of the population (our communities), improve the individual care experience and reduce or control the per capita cost of health care.

The American Hospital Association (AHA) in its framework for health reform, Health for Life, embraces the need to engage patients and families and contemplates the role of hospitals and health care systems in improving the total health of the population and community they are serving. Within this context, in 2012 the AHA Committee on Research decided to focus on patient and family engagement. This subject has taken on increasing importance with the growing recognition that actively engaging health care users in their care can improve outcomes and reduce health care costs. To adequately embrace the AHA's mission to improve the health of people and communities, hospitals must become more “activist” in their orientation and move “upstream”—that is, they must do more to engage patients earlier in the disease process.

Individual interactions with patients are the fundamental means by which hospitals and health care systems can improve the health of the patients and communities they serve. This two-way interaction requires health care providers to understand how they might present health matters to optimize the patient and family experience.

### What Is Health Care User Engagement?

There are many definitions of “health care user engagement.” To focus this work, the strategies and framework included in this guide will be built around this definition: **“a set of behaviors by health professionals, a set of organizational policies and procedures and a set of individual and collective mindsets and cultural philosophies that foster both the inclusion of patients and family members as active members of the health care team and encourage collaborative partnerships with patients and families, providers and communities.”**<sup>1</sup> In this report, “health care users” is the term used to denote all those who use health care services, though “consumer” and “customer” are also used frequently.

### Framework for Engaging Health Care Users

Achieving “Health for Life” is a team effort that requires actions from key players within the health care system to develop a culture that supports patient and family engagement. The Framework for Engaging Health Care Users diagram presents a continuum for engagement from information sharing to partnerships, with entry points for user engagement occurring at different levels of the health care system.<sup>2</sup>

## Framework for Engaging Health Care Users



Source: AHA COR, 2013.

## Strategies for Engaging Health Care Users

As hospitals and health care systems begin to play more of an activist role with their patients and communities and move upstream to intervene earlier in disease states, there are several barriers to acknowledge and consider. These are:

- Current volume-based reimbursement system that does not offer significant funding upfront toward health engagement initiatives
- Ambiguity surrounding the definition of health care user engagement and the large number of diverse strategies that hospitals can employ to achieve desired results
- Current professional culture and norms that intimidate patients in approaching their health care providers
- Low health literacy levels among patients
- Lack of measurement tools to assess where a patient is along the engagement continuum and how well an organization is doing in engaging health care users

Hospitals and health care systems can employ an array of strategies to increase consumer engagement at different levels of the health care system. See the table on page 6 for examples.



## Examples of Health Care User Engagement Strategies

Health Care System	Examples of Engagement Strategies
Community	<ul style="list-style-type: none"> <li>• Providing health education and health literacy classes</li> <li>• Providing healthy cooking and physical education classes</li> <li>• Using patient navigators and peers to provide support</li> <li>• Making local policy changes that promote healthier lifestyles (e.g., eliminating sugary drinks from school cafeterias)</li> </ul>
Organization	<ul style="list-style-type: none"> <li>• Using volunteers or patient advocates to support care</li> <li>• Involving patients and families in patient and family advisory councils, governance and other committees</li> <li>• Removing restrictions on visiting policies for families</li> <li>• Opening access to medical records</li> <li>• Using email and social media technology (e.g., Facebook, Twitter)</li> </ul>
Health Care Team	<ul style="list-style-type: none"> <li>• Using bedside change-of-shift reports</li> <li>• Involving patients and families in multidisciplinary rounds</li> <li>• Using patient- and family-activated rapid response</li> <li>• Providing shared decision-making tools</li> <li>• Using patient teach-back</li> <li>• Using clinic-based multidisciplinary care teams</li> </ul>
Individual	<ul style="list-style-type: none"> <li>• Seeking health information and knowledge</li> <li>• Adhering to treatment plans and medication regimens</li> <li>• Participating in shared decision making</li> <li>• Using online personal health records</li> <li>• Engaging in wellness activities</li> </ul>

Source: AHA COR, 2013.

The case studies in this report present approaches that hospitals and health care systems have already taken to engage health care users as active participants in their care.

### Community Level

- **Griffin Hospital** worked with nursing homes and home health agencies to standardize protocols and patient education materials to reduce readmissions. As a result, their readmissions fell from 15 percent to 7 percent during the course of the project.
- **Cambridge Health Alliance** worked with school nurses and families to improve asthma outcomes in children. Because of this, admissions for pediatric asthma fell by 45 percent and pediatric emergency department visits fell by 50 percent in seven years. The return on investment for the program is \$4 for every \$1 invested.
- **Methodist Le Bonheur Healthcare** partnered with the Congregational Health Network, a faith-based group, to improve care transitions. An analysis of 473 CHN participants found that their mortality rate was nearly one-half of the rate for nonenrolled patients with similar characteristics.
- **Southcentral Foundation** and **Kaiser Permanente**, both owned and managed by the customers they serve, are examples of a total health model.

## Organization Level

- **Georgia Health Sciences Health System** partnered with patients and families in all aspects of the health care system's operations. Patient and family advisors were instrumental in providing input on key operational and strategic decisions including anesthesia staffing, medication dispensing, patient handoffs, patient and family rounding, patient safety and the design of new services. As a result, in a three-year period, patient satisfaction scores increased and medication errors declined.
- Health care systems are also finding ways to engage their own workforce to become more involved in their overall health and care. **Saint Elizabeth's Medical Center, Bellin Health System** and **Sentara Healthcare** developed and established employee health and wellness programs that provide monetary incentives to encourage participation. These initiatives contributed to either reduction or slower growth of health care spending, while still improving the health and well-being of program participants.

## Health Care Team Level

- **Cincinnati Children's Hospital Medical Center** and **Helen DeVos Children's Hospital** focused on patients, families and the health care team when designing and implementing an approach for patient- and family-centered rounds. At Helen DeVos Children's Hospital, nursing units raised their patient satisfaction scores from below the 50th percentile to greater than the 90th percentile on a consistent basis.
- **Emory Healthcare** had patient and family advisors contribute to the development of protocols for conducting bedside change-of-shift reports and serve as instructors in training front-line staff. Patient satisfaction increased with overall nursing care augmenting from the 41st to 78th percentile on the Press Ganey survey. Quality outcomes also improved; hospital-acquired pressure ulcers decreased from 8.15 percent to 2.5 percent.
- **Informed Medical Decisions Foundation** supported research projects on shared decision making at primary and specialty care demonstration sites across the country.
- **Atlantic Health System** set flexible visiting hours. The system not only received strong support from internal staff to continue the open visitation policy but also increased patient satisfaction scores.
- **Geisinger Health System** established a medical home model, ProvenHealth Navigator, designed to reduce downstream costs—which occur later in the disease process—from the highest acuity by moving resources upstream or earlier in the disease process. It improved health coordination, enhanced patient access to primary care providers and provided more effective and efficient disease and case management. Over time, the program also reduced costs.

## Individual Level

- **Howard University Hospital** provided diabetes patients with access to personal health records to assist them in monitoring a range of clinical indicators pertinent to diabetic health. As a result, hemoglobin A1c levels fell by approximately 13 percent for patients participating in the program compared to an increase in levels for those not participating.
- **Ryhov Hospital** provided training for patients interested in managing their own dialysis. The 52 percent of renal patients who are on self-dialysis had fewer side effects and lower infection rates.

## The Future of Health Care User Engagement

While there is tremendous need to bridge the gap among consumers, health care professionals and policymakers to increase health care user engagement, there is also a collective awareness for change. Impressive health care user engagement initiatives and best practices are found in many health care systems across the country. Engaging users in health care is essential for transformation of the care system.



It requires a collaborative partnership and relationship among all stakeholders, including patients, families, communities, providers and other individuals involved in the industry.

The health care system is adapting to the ever-changing needs and demands of health care users. As the health care system evolves and user engagement matures, it creates opportunities to dramatically improve health care delivery. Many promising technologies and practices are being tested and many are yet to be discovered.

This report discusses many issues related to health care user engagement, but other emerging areas deserve appropriate attention. Though not discussed in as much detail in this report, these other topic areas are likely to have some significance in the future of health care user engagement, but they require further research to address questions surrounding them. These topic areas include:

- Consideration and integration of behavioral health and mental health as they relate to engagement at all four levels—the community, organization, team and individual
- Role of health plans as significant stakeholders in the engagement process
- Role of employers as drivers for creating a culture of health
- Emergence of new technologies that will facilitate patient, family and provider interactions; health education; treatments and overall engagement
- Role of social media as a means to enhance communication and networking with individuals and communities

Engaging patients, families and communities has the potential to be a “game changer” in the transformation of the health care system in the United States. Hospitals and health care systems can serve as laboratories for developing, testing, learning and disseminating new engagement practices. The impact of this type of engagement and the role that hospitals can play in leading this transformative element of system redesign in their own communities are foundational for achieving the Triple Aim in health care.

## Introduction

The mission statement of virtually every U.S. hospital is to improve the health of individuals and communities. According to the World Health Organization, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>3</sup> The Triple Aim for the U.S. health care system, a framework developed by the Institute for Healthcare Improvement, is to improve the health of the population (our communities), improve the individual care experience and reduce the per capita cost of health care.

The AHA framework for health care reform, Health for Life, embraces many of these core tenets. The Health for Life’s pillars—“Best Information,” “Highest Quality Care,” “Most Efficient, Affordable Care” and “Focus on Wellness”—encompass engaging patients and families and contemplate the hospital’s role in the larger sphere of improving the total health of the population and community being served. This expanded focus requires hospitals and health care systems to (1) move beyond the acute-care in-hospital management of episodes of illnesses, (2) encourage larger and longitudinal contact with people in their communities to maximize the health of each person and (3) create a better, safer, more efficient and affordable health care system.

It is important to understand that health care accounts for a small share of the factors determining the health of individuals and, by extension, the community. Genetic and demographic factors, socioeconomic status, education and lifestyle choices are overwhelmingly more important health determinants. Hospitals and health care systems often see patients far “downstream,” or late in the disease state of the population they serve. These health care organizations treat patients whose health status is determined by environmental, genetic and lifestyle choices beyond their control. To adequately embrace the AHA’s mission to improve the health of communities and individuals, hospitals must become more “activist” in their orientation and move “upstream”—that is, they must do more to engage patients earlier in the disease process.

The fundamental means by which hospitals and health care systems can affect the health of individuals and the communities they serve is through interactions with each patient. This two-way interaction requires health care providers to understand how they might diplomatically address health matters to optimize the experience and health of patients and their families. And patients have to understand a provider’s recommended course of action and follow the prescribed therapies and lifestyle changes. Attaining the optimal result for all parties involved is contingent on maintaining the delicate balance for recommended action and information uptake between the health care organization and patients. Unfortunately, most patient interactions fail to achieve this optimal result.

To understand this dynamic and examine ways that hospitals and health care systems can address these issues, the 2012 AHA Committee on Research focused on the topic of patient and family engagement. This report summarizes the literature on the rationale for health care user engagement, recommends actions that organizations should consider when developing initiatives to increase health care user engagement and highlights promising strategies found across hospital and health care system facilities.

## What Is Health Care User Engagement?

Health care user engagement is a broad concept. Many definitions place it in the context of patient-centered care, one of the six aims for improvement outlined in the 2001 Institute of Medicine's *Crossing the Quality Chasm: A New Health Care System for the 21st Century* and a central concept of the Triple Aim. For the IOM, patient-centered care is "providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions." ("Patient-centered care" and "person-centered care" are the most commonly used terms, and this report will use "patient-centered.")

National leadership organizations define health care user engagement in the context of patient-centered care in various ways. The Institute for Patient- and Family-Centered Care highlights bringing patient and family perspectives into the design and delivery of care with an emphasis on dignity and respect, information sharing, participation and collaboration.<sup>4</sup> The Commonwealth Fund defines seven attributes of patient-centered care including access to care, patient engagement in care, information systems, care coordination, integrated and comprehensive team care, patient-centered care surveys and publicly available information.<sup>5</sup> Planetree describes patient engagement as a model in which health care providers partner with patients and families to identify and satisfy the full range of patient needs and preferences. Staff dedicated to meeting the physical, emotional and spiritual needs of patients is a key element of this model.<sup>6</sup> The Center for Advancing Health defines patient-centered care as "actions individuals must take to obtain the greatest benefit from the health care services available to them."<sup>7</sup> The CFAH focuses on more than 40 behaviors of individuals to become more engaged rather than on behaviors of providers or policies of organizations. These behaviors are grouped into 10 categories and together make up the "Engagement Behavior Framework" (See Appendix).<sup>8</sup> Despite differences across these definitions, patient and family engagement is universally viewed as the mechanism to achieve patient- and family-centered care.

This guide will build its framework and strategies around **"a set of behaviors by health professionals, a set of organizational policies and procedures and a set of individual and collective mindsets and cultural philosophies that foster both the inclusion of patients and family members as active members of the health care team and encourage collaborative partnerships with patients and families, providers and communities."**<sup>9</sup> This definition, adapted from the Agency for Healthcare Research and Quality's *Guide to Patient and Family Engagement: Environmental Scan Report*, shares many of the elements associated with definitions from other organizations. The definition also provides clarity of purpose for hospitals and health care systems to develop and implement strategies that support patient and family engagement.

## Why Health Care User Engagement?

Improving overall health in the United States requires active participation from all segments of the population: policymakers, public health agencies, providers, payers and health care users. A tremendous opportunity to improve health lies in optimizing health care user engagement because 40 percent of all deaths in the United States are attributed to personal behavior.<sup>10</sup>

Studies have also shown that on average only half of adult patients receive the recommended care<sup>11</sup> according to best practices, and the results for children are similar.<sup>12</sup> There are myriad reasons for this gap including the fragmentation of the current health care system, the payment system that rewards volume instead of value and a care delivery system that historically has been designed without input and involvement from the individuals that the system serves.<sup>13, 14</sup>

More and more researchers, policymakers, patients and providers are embracing health care user engagement as an important factor to improve quality and outcomes when providing care. Engaged health

care users are more likely to comply with their treatment and prevention plans and less likely to engage in unhealthy behaviors, and they have fewer emergency department visits and hospitalizations.<sup>15</sup> Additionally when patients and families are involved, hospitals and health care systems have an opportunity to improve quality and reduce medical errors, health care-associated infections and readmissions.<sup>16</sup>

Other forces in the health care environment are creating momentum for change. The increasing rates of chronic disease, changing patient demographics, advances in medical technology, greater use of smart phones and the Internet, new models of health care delivery (e.g., patient-centered medical homes and accountable care organizations) and emerging value-based payment systems—all these forces are pressing organizations to take a more proactive role and approach to patient engagement. This expansion includes seeking ways to better engage patients in shared decision making and self-management behaviors and involving the community in supporting care. These components are critical strategies as the population ages and management of chronic diseases becomes the norm.

## **Progression of Health Care User Involvement**

As providers' practices have evolved, health care markets have developed and the identities and functions of health care system stakeholders have changed, patient roles also have changed. Below are several forces that have progressively expanded the patient's role in health care delivery.<sup>17</sup>

### **Informed Consent**

Early in the 20th century, judicial courts began to recognize the right of patient self-determination. These courts laid the foundation for today's informed consent doctrine requiring physicians to obtain consent for treatment after disclosing factors such as the patient's diagnosis, the proposed treatment's nature and purpose, treatment risks and treatment alternatives.

This type of information transfer brings the patient's knowledge base closer to that of the physician's, making the health care provider and user relationship less hierarchical and providing the patient with an opportunity to direct his or her care path.

### **Beyond Consent: Patient-Centered Care**

Like the commitment to informed consent, patient-centeredness requires informed patient participation in decision making and care that caters to the patient's needs and preferences. It requires more active involvement than just the grant or denial of consent. In patient-centered care, patients exercise greater autonomy.

There are six core attributes of patient-centered care:<sup>18</sup>

1. Education and shared knowledge
2. Involvement of family and friends
3. Collaboration and team management
4. Sensitivity to nonmedical and spiritual dimensions of care
5. Respect for patient needs and preferences
6. Free flow and accessibility of information

## Barriers to Health Care User Engagement

As health care leaders move to embrace health care user engagement, they have encountered and will continue to face considerable barriers. The current volume-based reimbursement system does not offer significant upfront funding toward these initiatives because savings and outcome improvements are typically realized later. Additionally, the ambiguity surrounding the definition of health care user engagement and the large number of diverse strategies that hospitals can employ to achieve desired results—from medical home models to nutrition classes and shared decision making—make it challenging to identify which aspects of engagement represent the best opportunities for investment, especially with limited time and resources.

Barriers to change can be attitudinal and related to professional culture and norms, with older providers tending to be more paternalistic in their approach. The “physician knows best” culture is at odds with the tenets of patient-centeredness. Many patients are often overwhelmed when faced with navigating the health care system and can be intimidated by health care professionals. These patients believe they lack the necessary skills to seek out information and effectively use the information once they receive it. For example, an online survey asked 1,340 adults how they would want to be involved in their own treatment if they were patients suffering from heart disease. Only one in seven respondents was willing to bring up a disagreement with the physician if the physician’s recommendation clashed with their own treatment preference.<sup>19</sup>

Motivational factors can also play an important role. In a recent meta-analysis of the literature conducted by Ng et al., when patients perceive respect for their autonomy in the health care setting, they experience better physical and emotional health.<sup>20</sup> Poor health literacy skills are a huge barrier and associated with increased hospitalizations and emergency department use, poor medication adherence and low screening and immunization rates. The relationship between health literacy and health outcomes is particularly true for the elderly. Additionally, studies show that health literacy may also be inversely associated with health care disparities.<sup>21</sup>

Another significant obstacle is the lack of measurement tools to assess where a patient is along the engagement continuum and how well an organization is doing in engaging health care users. This is changing with the development of the Patient Activation Measure by Judith Hibbard, for use with chronic disease patients.<sup>22</sup> Hospitals are also starting to think about using available patient-reported outcome measures along with patient experience and quality-of-care measures to gain a better idea of the quality of care they are providing. Patient-reported outcome measures assess health, functional status and quality of life from the patient’s perspective and can be an important tool in engaging patients in their care.

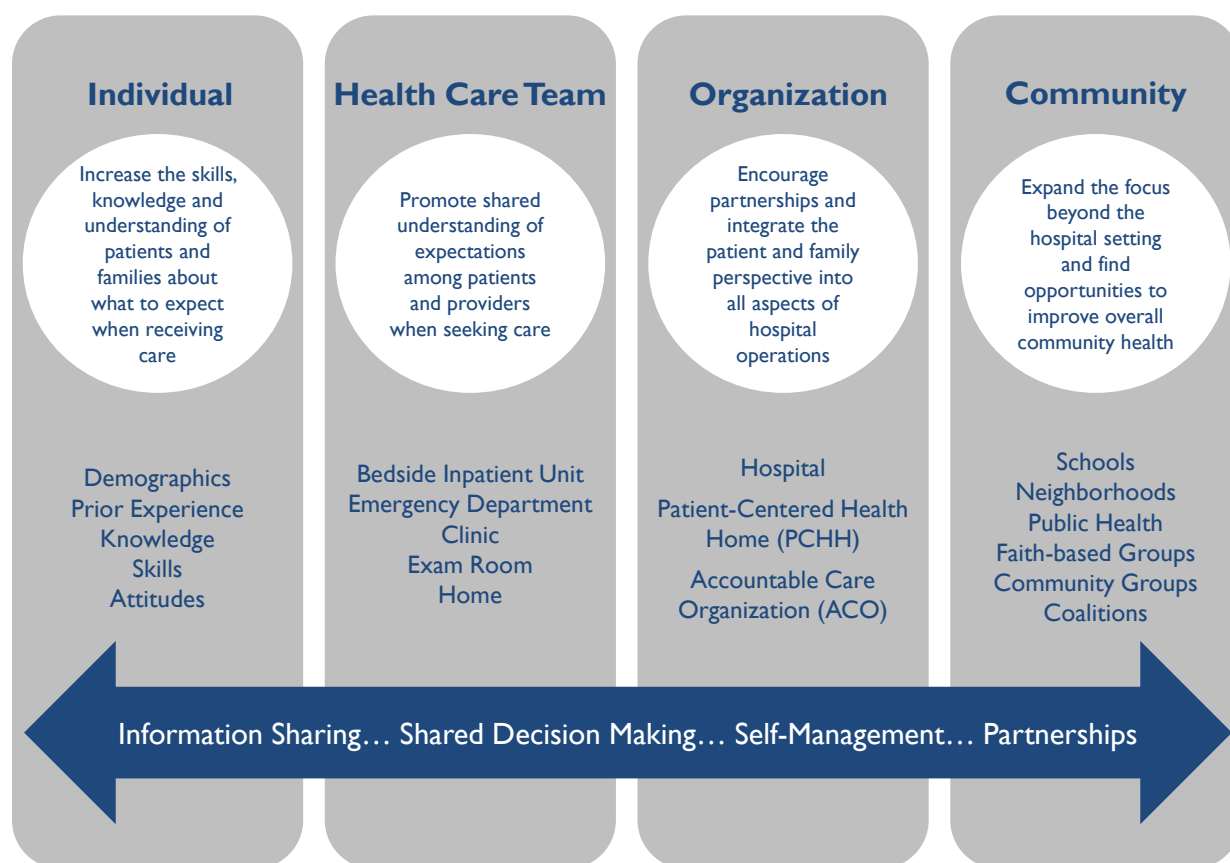
Despite these challenges, hospital and health care system leaders are recognizing the importance of patient engagement in increasing quality and safety, developing care coordination activities, advancing preventive services, expanding access and improving patient experience scores. Some of the financial incentives are not yet fully aligned, but specific and considerable efforts to engage health care users in the current volume-based payment systems will be critical in the future value-based market.

## Framework for Engaging Health Care Users

Achieving “Health for Life” is a team effort that requires actions from key players within the health care system in developing a culture that supports patient and family engagement. Hospital leaders and clinical providers will need to create a culture that brings the patient and family perspective into the design and delivery of care programs and practices. Individuals (patients and families) will need the necessary knowledge and skills to become more involved in their care. Meanwhile, the broader community will need to align policies and programs that are responsive to patient and family needs and support engagement efforts. As care shifts away from acute, episodic care to chronic disease management, hospitals will have to expand their focus beyond the inpatient setting, create mutual relationships and think more broadly and creatively with different stakeholders when developing strategies for health care user engagement.

The Framework for Engaging Health Care Users in Figure 1 shows how health care organizations can actively engage with health care users. This framework presents a continuum for engagement from information sharing to partnerships, with entry points for user engagement occurring at different levels of the health care system.<sup>23</sup> Strategies within each of the different entry points can be mutually reinforcing and should encourage collaborative partnerships across each level of the health care system.

**Figure 1: Framework for Engaging Health Care Users**



Source: AHA COR, 2013.



At the **individual level**, the focus is on patients and families and includes strategies to increase their skills, knowledge and understanding of what to expect when receiving care. For example, some hospitals provide patients with informational packets upon admission and have educational resource centers available for access. Other hospitals assign transition coaches to help patients and families understand discharge instructions and prepare questions for their physicians during a follow-up visit. There are also facilities that provide patients with pocket guides to aid in their conversations with physicians. Additionally, other hospitals combine technology with techniques such as coaching or mentoring to prepare patients to become more actively involved in their care.<sup>24</sup> These and other strategies allow patients to take ownership of their care. With more information and guidance, patients can make better, well-informed decisions and even augment a physician's care plan to reflect personal preferences and individual values.

At the **health care team level**, point-of-care strategies can be implemented such as patient and family rounds, patient and family involvement in bedside change-of-shift reports, patient- and family-activated rapid response, and open charting. The Center for Advancing Health has developed a "Patient-Clinician Pact," which includes a list of responsibilities for patients paired with a set of responsibilities for clinicians grouped around "sharing information, shared decision making and responsibility for care."<sup>25</sup> The CFAH also suggests developing an information pamphlet for patients giving them the "rules of engagement" for the physician's office or clinic. This pamphlet can include instructions for the type of information that patients should bring with them to each appointment (e.g., medication list, recent test results) and the procedures for making office appointments and where to go for care when the office is closed. A similar type of instructional pamphlet could be developed for patients at hospital discharge or at other points of transition or entry into the health care system. Strategies at this level allow patients to participate in the system and play a role in health care units. As a result, patients and their providers build a shared understanding of expectations when seeking and receiving care.

At the **organization level**, hospitals and health care systems can encourage partnerships with patients and families by involving them in program planning and development, patient safety, and quality improvement processes by establishing patient and family advisory councils and including them on quality improvement and other hospital management and committees. The ultimate goal is to integrate the patient and family perspective into all aspects of hospital operations. To do this, a culture that is conducive and supportive of patient and family engagement is required. Some hospitals define behaviors associated with patient-centered care and incorporate them into staff position descriptions and provide role-playing opportunities during new employee orientation, thus incorporating patient-centered concepts into daily practice. Other hospitals have asked patients and families to serve as faculty members when training staff on patient-centered concepts and provide opportunities for students to shadow patients and their families to understand what they are experiencing when they visit the hospital. Strategies at the organizational level provide patients and families the opportunity to influence health care systems and integrate perspectives from their experiences.

At the **community level**, hospitals can also expand their focus beyond the facility by providing care to patients in the home, partnering with the community on care transitions and finding opportunities to improve community health overall. Hospitals are working with schools, faith-based organizations and other community partners to provide screenings, health education and wellness programs. Some hospitals are trying novel approaches such as using peer mentors to improve and manage chronic conditions like diabetes.<sup>26</sup> Hospitals are also collaborating with professional associations, nonprofit organizations and community members to deliver information and engage health care users on issues such as patient safety and health reform. Aside from hospitals, states are taking steps to increase public health engagement. Open board meetings are occurring throughout the United States. Massachusetts, for example, posts notices of upcoming meetings from its Department of Public Health website.<sup>27</sup> At this level, health care systems take an activist role and move their level of disease intervention "upstream." Through early detection and engagement, health care users are more cognizant of their well-being.

## Strategies for Engaging Health Care Users

Strategies to increase health care user engagement at different levels of the health care system are listed in Table 1. Hospitals and care systems may not be able to pursue all these strategies, but even small steps in one of the areas can yield beneficial results. The four levels of the health care system detailed in the table are community, organization (governance, executive leadership, management, and clinical), health care team (bedside, inpatient unit, exam room, home) and individuals (patients and families). Each of the strategies involves implementing different programs, both big and small, that can increase health care user engagement.

**Table 1: Examples of Patient and Family Engagement Strategies**

Health Care System	Description	Examples of Engagement Strategies
Community	Communities have an important role to play in supporting residents living with chronic disease. A growing number of hospitals and health systems are partnering with community health centers and public health agencies to involve the community in engaging in healthier behaviors and self-management activities.	<ul style="list-style-type: none"> <li>• Providing health education and health literacy classes</li> <li>• Providing healthy cooking and physical education classes</li> <li>• Using patient navigators and peers to provide support</li> <li>• Making local policy changes that promote healthier lifestyles (e.g., eliminating sugary drinks from school cafeterias)</li> </ul>
Organization	Health care organizations can implement many programs and changes in care delivery to engage patients throughout the continuum of care and involve them in improving quality and the patient experience.	<ul style="list-style-type: none"> <li>• Using volunteers or patient advocates to support care</li> <li>• Involving patients and families in patient and family advisory councils, governance and other committees</li> <li>• Removing restrictions on visiting policies for families</li> <li>• Opening access to medical records</li> <li>• Using email and social media technology (e.g., Facebook, Twitter)</li> </ul>
Health Care Team	The growing incidence of chronic disease combined with an expanded patient base has placed more responsibility onto clinicians practicing both inside and outside of the hospital. Clinicians must work with each other and with patients to design individual care plans to achieve better outcomes.	<ul style="list-style-type: none"> <li>• Using bedside change-of-shift reports</li> <li>• Involving patients and families in multidisciplinary rounds</li> <li>• Using patient- and family-activated rapid response</li> <li>• Providing shared decision-making tools</li> <li>• Using patient teach-back</li> <li>• Using clinic-based multidisciplinary care teams</li> </ul>

Health Care System	Description	Examples of Engagement Strategies
Individual (Patients and Families)	Clinical advances have the ability to improve the quality of life for the majority of patients. To receive the full benefit, patients must actively manage their conditions to help prevent complications. For example, new HIV/AIDS drugs extend life, but patients must maintain the necessary regimens for success.	<ul style="list-style-type: none"> <li>• Seeking health information and knowledge</li> <li>• Adhering to treatment plans and medication regimens</li> <li>• Participating in shared decision making</li> <li>• Using online personal health records</li> <li>• Engaging in wellness activities</li> </ul>

## Getting Started: Implementing Organizational Change

An organization's culture—its norms, values, beliefs and behaviors—influences its capacity to pursue and adopt patient engagement strategies. Changing culture to support health care user engagement is a long-term and interactive process that begins with strong leadership. Leaders set the tone by actively building awareness of the importance of this issue and visibly supporting this core value. Conducting an assessment to understand where the organization is in its journey to engage patients and families is one way to identify opportunities and build awareness. Several tools are available in the literature to use in conducting this assessment. Here are examples of questions to consider:

- Does the hospital have an active patient and family advisory council?
- Do patients or families serve on the hospital's quality improvement project teams?
- Does the hospital have open visiting hours?

Learning from patients and families that use services is key to the assessment process. Although hospitals leaders can examine their Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) results to enhance understanding of how patients view their current experiences, this should not suffice. Hospitals should supplement the survey approach by asking patients and families questions about their recent visit or hospitalization. Some hospital leaders begin with patient focus groups and ask them to discuss their recent experience, or leaders round on patient floors. Patient stories can be a powerful tool for determining gaps and identifying opportunities of where to begin. Other strategies include having leaders begin each hospital meeting with a “mission” moment by reading a letter from a patient or relaying a story. Whatever approach is used, scrutinizing the care experience through the patient's perspective is important.

Once an overall assessment is complete, hospitals can begin to take steps necessary to target strategies for engagement. One-size-fits-all passive strategies will not be as successful to support patient and family engagement as tailored, individually focused activities. Important insights can be gained from understanding the factors that are outside the control of health care organizations but relate to the hospital patient population (e.g., demographics, education level, socioeconomic status, housing conditions and neighborhood violence). These factors should also be considered when developing strategies and programs for engagement. With this knowledge, hospitals will be in a better position to develop effective programs to encourage behavior change.

## Steps to Engage Health Care Consumers

A health care organization can approach health care user engagement by first knowing its own patients well—as individuals and population subgroups. Patient information can be collected and segmented by disease status, age, gender, geographic region, socioeconomic status, race, ethnicity, language preference, etc. This process of identifying the patient population ensures that information and programs provided are appropriate for the individuals and community served by the hospital.

Organizations must identify the results they hope to achieve before developing patient and family engagement programs. Having a clear vision for a proposed change can provide a road map for success. This requires an understanding of patient and family engagement, its importance and the behaviors that foster it.<sup>28</sup> Strategy for change begins with a strong leader, particularly someone who will advocate and participate in a visible way to move the initiative forward. Health care stakeholders also should actively listen and incorporate ideas suggested by the target patient population.

As when implementing any new initiative, changes in the workforce should be expected and addressed. Educating health care providers about the availability of these new programs and encouraging participation in ways that foster patient engagement are essential for success, particularly in understanding and acknowledging the different challenges at the patient level including cultural differences, socioeconomic status, language barriers and literacy levels, issues of noncompliance and lifestyle choices. Actively including clinical providers, health care staff and patients and their families in the planning and implementation process will help get buy-in and mutual support for change.

Communication is a two-way process and involves asking and listening by both sides. This two-way process ensures that hospital and clinical providers are addressing the concerns of patients and families, who also need to be reached through mediums and language that they prefer and can comprehend.

Once the appropriate programs have been implemented, they must be supported and sustained to achieve the best health outcomes. Too often, new programs are developed without outlining the shared set of expectations for both patients and providers. Therefore, infrastructure to support the initiative, such as ongoing training, providing internal incentives for participation and incorporating necessary improvements in a continuous manner, is essential.

Organizations must consistently measure outcomes at the individual level and in aggregate to monitor progress and make adjustments as needed. Progress should be monitored, whenever possible from the patient's perspective, and include measures of patient-reported outcomes along with measures of patient experience and clinical quality.

## Case Studies: Engaging Health Care Users

The remaining sections of this report present various health care user engagement strategies that have been deployed at health care organizations throughout the United States, either independently or through external partnerships. These initiatives illustrate how patient and family engagement strategies can focus on populations large and small, and on frequent hospital users and those who need more preventive screening and support to change health behaviors. The initiatives also demonstrate how health care users have responded to engagement efforts. Results show that patients and families have a strong interest and willingness to be more actively involved in their health and care.

While some of these health care user engagement initiatives require large investments, successful, proven results can still be achieved for those that do not. Some of the strategies are more widespread than others and have already demonstrated specific benefits; other strategies will take more time to gain prevalence yet are still effective. Some initiatives are focused on a single site of care while others overlap sites. In addition, many health care user engagement initiatives have expanded to involve the community and the larger field of public health. Case studies are organized according to the Framework for Engaging Health Care Users (page 13) and include strategies for engagement at different levels of the health care system.

### Community Level

- Customer-owned Model of Care at Southcentral Foundation
- The Congregational Health Network at Methodist Le Bonheur Healthcare
- Collaborative Effort to Reduce Readmissions at Griffin Hospital
- Public Health Partnership at Cambridge Health Alliance
- Total Community Health at Kaiser Permanente

### Organization Level

- Organizational Level Partnerships at Georgia Health Sciences Health System
- Total Health Model at Bellin Health System
- Mission: Health at Sentara Healthcare
- WellnessWorks at Saint Elizabeth's Medical Center

### Health Care Team Level

- Patient- and Family-Centered Rounds at Cincinnati Children's Hospital Medical Center
- Patient- and Family-Centered Rounds at Helen DeVos Children's Hospital
- Shared Decision Making at Informed Medical Decisions Foundation
- Bedside Change-of-Shift Reporting at Emory Healthcare
- Flexible Visiting Hours at Atlantic Health System
- ProvenHealth Navigation at Geisinger Health System

### Individual Level

- Use of Personal Health Records at Howard University Hospital
- Patient-Driven Care at Ryhov Hospital

## Strategies at the Community Level

To successfully engage health care consumers across the care system, hospitals are turning to nonclinical participants—employees and volunteers—to improve care outcomes. Hospitals are also pursuing partnerships with communities and public health entities to support patient and family self-management skills, participation in wellness activities and changes in local policies.

### *Customer-owned Model of Care at Southcentral Foundation*

#### **Southcentral Foundation**

Southcentral Foundation (SCF) is a nonprofit health care organization owned by the Alaska Native people and located in Anchorage, Alaska. This customer-owned system of care, called the SCF Nuka System of Care, provides a range of medical, dental, behavioral and complementary medicine, traditional healing, home-based services and education. SCF, together with the Alaska Native Tribal Health Consortium, jointly owns the Alaska Native Medical Center, which includes a 150-bed hospital providing acute, inpatient and specialty care

#### **Background**

Before SCF transitioned to a customer-owned system, care was fragmented, patient satisfaction was poor and staff turnover was high. Alaska Native leaders decided to create a customer-owned system of care built on the values of Alaska Native people.

#### **Intervention**

SCF underwent a whole system transformation after moving from the Indian Health Service to a customer-owned system of care. Every aspect of the care system is designed by the customer-owners. The board of directors is made up of all customer-owners, and 54 percent of the workforce is customer-owners. In addition, a variety of approaches are utilized to listen to customer-owners—such as surveys and focus groups—and the feedback is incorporated into care delivery. A multidisciplinary team, called an Integrated Care Team (ICT) at SCF, consists of a primary care provider, a certified medical assistant, a full-time RN, case manager, an administrative assistant providing care coordination support, and a behaviorist. The ICT works together with a panel of customer-owners who have chosen their own primary care provider, and customer-owners develop a relationship with their chosen team.

SCF removes barriers to care by giving customer-owners access to the team's direct phone numbers and also encouraging email communication. If a problem cannot be handled over the telephone or by email, customer-owners get a same-day appointment with the appropriate member of the ICT.

Key elements of the system's success are the recruitment process and training and orienting staff to this approach. SCF conducts group interviews, uses behavioral interviewing techniques and makes same-day hiring decisions as often as possible. New hires have an extensive orientation and onboarding process that includes information about the customer-owner philosophy of care and the culture of the Alaska Native people. Front-desk employees receive additional training before beginning their positions and participate in a six-month mentoring process. All employees are trained in quality improvement. Clinical staff work in teams and are encouraged to work to their highest skill level.

#### **Results**

Since the implementation of this system, positive results have been achieved in utilization, customer-owner and employee satisfaction, and clinical quality outcomes.



## Lessons Learned

Staff can initially be uncomfortable with the shifting of responsibilities created by encouraging the clinical team to work to the top of its level. Carefully screening and matching new employees with the right team, making sure that employees are trained in their new roles and providing them with appropriate supervision are all important factors in a successful transition.<sup>29, 30</sup>

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## ***The Congregational Health Network at Methodist Le Bonheur Healthcare***

### **Congregational Health Network**

The Congregational Health Network (CHN) is a partnership between Methodist Le Bonheur Healthcare and almost 400 churches in Memphis, Tennessee. CHN is designed to maintain a smooth transition from inpatient hospital admission to home.

### **Background**

The African-American population in Memphis had a higher readmission rate than the rest of the population. Traditionally, this population had lower levels of support after discharge, and the church remained a powerful organization within the community. The health care system employs the equivalent of nine full-time employees at CHN, and more than 500 volunteers participate as well.

### **Intervention**

CHN provides health education to parishioners and assigns parishioners as liaisons should any congregant need hospital care. Congregants that choose to be enrolled in CHN are flagged by the health care system's electronic health record upon hospital admission. A hospital-employed navigator meets with the flagged patient to establish his or her needs once discharged and then works with the affiliated congregation's volunteer health liaison to arrange post-discharge services and facilitate the transition back into the home. The church volunteer provides education and comfort to the patient.

The health care system approached each of the member churches to form a partnership. Participating CHNs are assigned according to level of involvement. Level of involvement by churches ranges from being a good health role model to a congregation with enrollees that participate in data analysis and help with further program development. Additionally, the health care system supports the liaisons, who communicate directly with patients to encourage program enrollment.

### **Results**

More than 12,000 congregants from approximately 400 churches have signed up to be members of the program. CHN seeks regular input from church partners and also analyzes data to ensure ongoing progress and potential improvement. An analysis of 473 CHN participants found that the mortality rate was nearly one-half of the rate for nonenrolled patients with similar characteristics. The same study found that CHN members had lower health care charges than nonparticipants, lower inpatient utilization and higher patient satisfaction with the health care system.<sup>31</sup>

[Congregational Health Network at Methodist Le Bonheur Healthcare](#)

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## ***Collaborative Effort to Reduce Readmissions at Griffin Hospital***

### **Griffin Hospital**

Griffin Hospital is a 160-bed acute care community hospital located in Derby, Connecticut. It is the flagship hospital for Planetree, Inc., an organization that promotes patient-centered care.

### **Background**

Griffin Hospital examined its readmissions and determined that there were too many readmissions for patients with congestive heart failure. Hospital leaders realized they needed to extend their patient-centered model of care into the community and partner with long-term care organizations to do so. Leaders began by reaching out to nursing homes and home health facilities to gain a better understanding of each organization's role and the factors contributing to readmissions. Through this process, the hospital learned that (1) patients were getting too much sodium in their diets, a factor in many readmissions for CHF, (2) there were neither consistent programs for home care services after discharge nor follow-up with primary care and cardiac physicians and (3) each organization used different teaching tools and protocols.

### **Intervention**

The hospital invited skilled nursing facilities and home health agencies to join a collaborative effort to reduce readmissions. This collaborative, Valley Gateway to Health, implemented a shared model of care transitions with standardized teaching tools and protocols for patients and providers.

Patients with CHF who arrive at the emergency department are seen by a multidisciplinary team consisting of a cardiologist, nutritionist, case manager and pharmacist. Each team member meets with the patient prior to discharge and ensures that the patient understands medical prescriptions, diet plans and exercise needs and recognizes which symptoms require a call to the cardiologist or primary care physician. An outpatient CHF clinic provides intravenous medications since many nursing homes are not licensed to do so in their facilities. The hospital follows up with patients and nursing homes weekly for one month after discharge. Physicians learn how to provide information at discharge in ways that patients can understand. The teach-back program was implemented, using a brochure developed by the University of North Carolina. The brochure provides information on actions patients can take to prevent readmissions. Nursing homes and home health facilities use the same brochure so that patients receive a consistent message.

### **Results**

CHF readmissions fell from 15 percent to 7 percent during the course of the project. From 2010 through 2011, the internal heart to heart failure readmissions decreased from 13.2 percent to 8.6 percent, and heart failure to any readmission decreased from 30.2 percent to 23 percent.<sup>32</sup>

### **Lessons Learned**

The CHF population is largely elderly, so it is important to identify members of a patient's support system and educate them as well.<sup>33</sup>

[Griffin Hospital  
http://www.griffinhealth.org/](http://www.griffinhealth.org/)

## Public Health Partnership at Cambridge Health Alliance

### Cambridge Health Alliance

Cambridge Health Alliance (CHA) is an integrated health system located in Cambridge, Massachusetts. It includes three hospitals, 12 primary care practices, and specialty centers. CHA also provides public health services to the city of Cambridge.

### Background

CHA implemented several public health community programs to address pediatric asthma, obesity and chronic disease management. First, the Childhood Asthma Program involves a collaboration of CHA with pediatricians, school nurses and local public health departments. Second, CHA developed a centralized complex care management team that interacts with patients extensively in the community. Third, CHA's Institute for Community Health and the Cambridge Health Department partnered to prevent obesity.

### Interventions

*Asthma:* A web-based registry for pediatric patients was developed. The information is shared with parents and, with parental permission, school nurses, emergency departments, primary care physicians and community health workers. The registry tracks treatments and outcomes and provides decision support prompts. Children are grouped according to asthma severity. The care team works with patients to develop an asthma action plan and provides education. CHA also provides school-based peer support groups and has developed online tools and resources to support patients and families. Additionally, a nurse and community health worker from the Cambridge Health Department Healthy Homes project conducts home visits to assess environmental triggers and help asthma-proof the home.

*Centralized care:* The centralized complex care management program provides a multidisciplinary team of nurses, community health workers and social workers to engage high-risk and chronically ill patients in care and help them with a variety of clinically and nonclinically related tasks, such as transportation, housing and child care. These tasks may sound simple, but they are often very difficult for this population and can mean the difference between a well-managed disease and significant complications.

*Obesity:* CHA has long supported obesity prevention in the community through its partnerships with the Institute for Community Health, city leadership and local health and school departments. Community liaisons work with community organizations to develop programming and support policy change, while volunteer health advisors provide education on diabetes prevention at community events and local churches.

### Results

*Asthma:* From 2002 to 2009, admissions for pediatric asthma fell by 45 percent, and pediatric emergency department visits fell by 50 percent. The return on investment (ROI) has been \$4 for every \$1 invested in the program.

*Centralized care:* The centralized complex care management program has generated a 5:1 ROI over its first six months of operation.

*Obesity:* In Cambridge, the proportion of children with healthy weight improved from 61 percent in 2004 to 62.4 percent in 2007, and the overall prevalence of obesity among a cohort of monitored children decreased by 2.2 percentage points ( $p < 0.05$ ) from 20.2 percent to 18 percent. From 2004 to 2007, almost a quarter (24 percent) of children who were obese dropped to the overweight category, while 40 percent of children who were overweight moved into the healthy weight category.

## Lessons Learned

*Asthma:* The asthma registry helps the care team be more proactive with managing asthma and helps to coordinate care. It also equips providers with data to identify and measure how well they are managing asthma patients. Having access to this type of data was extremely motivating for physicians.<sup>34</sup>

*Centralized care:* The centralized complex care management team has reached out to patients in the communities where they live by using insurance and provider EMR data to target the highest risk patients. These patients are already incurring the highest health care costs or are predicted to have the highest costs.

*Obesity:* To curtail the obesity epidemic at the community level, strong relationships with community organizations, public health agencies, schools and city planners are required.

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## **Total Community Health at Kaiser Permanente**

### **Kaiser Permanente**

Kaiser Permanente is a health care provider and nonprofit health plan that serves more than 9 million members in nine states and the District of Columbia.

### **Background**

At the core of Kaiser Permanente's mission is focusing on the continuum of health and not just health care. What hasn't always been central is explicitly talking about that full continuum. That shift was driven by comprehensive brand research asking members and nonmembers what was important to them. Their responses had very little to do with medical care; rather, they focused on relationships, levels of safety and security, and feelings of well-being. Kaiser Permanente leadership recognized the value of communicating how total health is not just the absence of illness but also a positive state that involves mind, body and spirit. To deliver on that promise, Kaiser Permanente deepened its commitment to extend beyond the medical setting to what is happening in the homes, neighborhoods and communities of the people it serves.

### **Intervention**

To facilitate the journey to total health, Kaiser Permanente supports all aspects of a person's well-being and examines every aspect of the organization to determine how it contributes in a positive way to total health. Kaiser Permanente has created programs in both the clinic and the community to support the full continuum of health for members. Exercise as a Vital Sign is an innovative effort in which patients are asked about their level of physical activity and responses are recorded in the electronic health record. If fitness levels are low, patients are counseled on strategies for increasing activity, particularly by walking 30 minutes a day, five days a week.<sup>35</sup> For 25 years, Kaiser Permanente's Educational Theatre Program<sup>36</sup> has used live theater, music and dance productions to teach children and adults about healthy eating, physical activity and self-esteem. Environmental stewardship is also an important part of the total health philosophy, and the organization has committed to reducing greenhouse gas emissions and increasing how much locally produced, pesticide-free food it buys in all of its facilities.

Additionally, Kaiser Permanente continues to invest in Community Health Initiatives/Healthy Eating Active Living partnerships, which were first launched in 2004 and focus on prevention of obesity and its related diseases through improved healthy food choices and support for physical activity.

### **Results**

The Community Health Initiatives have expanded from just three communities eight years ago to more than 40 locales today, supported by a cumulative investment of more than \$236 million. In addition, Kaiser Permanente has been a partner for high-profile health initiatives such as "The Weight of the Nation," the documentary and initiative targeting obesity in America; the Let's Move! initiative Michelle Obama kicked off to end childhood obesity within a generation; and the Partnership for a Healthier America, through which Kaiser Permanente committed publicly to offer healthier hospital food.



## Lessons Learned

According to Kaiser Permanente, the most important lesson is that health systems don't have to "do it all" as they evolve into a health provider that extends care beyond the clinical setting. Looking at health through the model of the whole person—mind, body and spirit—removes the artificial distinction of community engagement as "nice to have" and instead positions it as an indispensable part of the organization's care model. A second key lesson is that health systems don't have to go it alone. Kaiser Permanente has advanced numerous community-based services by partnering with subject experts and organizations that benefit from Kaiser Permanente's resources and expertise. Kaiser Permanente was able to create a culture in which people look to health organizations not just for care, but as trusted partners in all facets of total health.

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## Strategies at the Organization Level

Engaging patients and families at the organizational level provides an opportunity to integrate patient and family perspectives into all aspects of the care delivery process. Therefore, a culture that is conducive and supportive of engagement is essential at the organizational level. The 2011 AHA Long-Range Policy Committee Report, [A Call to Action: Creating a Culture of Health](#), highlights current health and wellness practices that hospitals have already established within their workforce. The report also provides examples of promising strategies and how-to recommendations to the field as health care organizations serve as drivers for change toward healthier communities.

### **Organizational Level Partnerships at Georgia Health Sciences Health System**

#### **Georgia Health Sciences Health System**

Georgia Health Sciences Health System is located in Augusta, Georgia. The health care system consists of a 478-bed medical center, more than 80 outpatient practice sites, a critical care center and a 154-bed Children's Medical Center.

#### **Background**

The Georgia Health Sciences Medical Center and Children's Medical Center began a patient- and family-centered journey in the 1990s when families expressed interest in being more involved with care for their children in intensive care units. Parents began meeting regularly with ICU clinicians to discuss issues and provide feedback about the care. With the building of a new Children's Medical Center, there was an opportunity to involve patients and families in its design.

#### **Intervention**

Beginning with the pediatric units, a steering committee was established. Training sessions were held for staff and families to learn how to work together. A visioning retreat was held for hospital leaders to define core values and family-centered concepts, and priorities were identified and agreed upon. A family-centered services committee, which included staff and families, was formed to identify ways to integrate these concepts and strategies into all aspects of the hospital's operations. In the late 1990s, a strategic plan was developed to implement patient- and family-centered care throughout the organization. The position of Director of Family Services Development was created, and the hospital hired the mother of a child with special health care needs to make sure that patient and family perspectives were represented in all aspects of the care experience. Patient and family engagement was then spread to the adult campus.

To support this work, all new staff members received orientation on patient- and family-centered care and the role of patient and family advisors. Patient-centered behaviors were defined and included in position descriptions, performance evaluations and annual reviews.

#### **Results**

More than 200 patients and family advisors participate in advisory councils and hospital committees, including the children's advisory committee, Kids' ART (Architectural and Recreational Team), which gives recommendations to make the facilities more children friendly. Practice areas and affiliated ambulatory clinics also have a family advisory council. These patient and family advisors have provided input on key operational and strategic decisions including anesthesia staffing, medication dispensing, patient handoffs, patient and family rounding, patient safety and the design of new services. For example, patient and family advisors provided guidance for the design of the Neuroscience Center for Excellence, a patient care unit for stroke patients and individuals undergoing brain surgery. The new unit was designed with the goal of engaging families in care. In a three-year period, patient satisfaction scores increased and

medication errors declined. In addition, patient and family advisors serve as faculty to the Health Sciences University.

### **Lessons Learned**

Senior leadership is key as leaders need to model the behaviors of patient- and family-centered care and continually find ways to encourage patient and family involvement.<sup>37, 38, 39</sup>

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## Total Health Model at Bellin Health System

### Bellin Health System

Bellin Health System is a nonprofit integrated health care delivery system based in Green Bay, Wisconsin. It has two hospitals, located in Wisconsin and Michigan.<sup>40</sup>

### Background

Annual health care spending at Bellin Health System reached \$10 million in 2002, and that figure was projected to increase by \$3 million the following year.<sup>41</sup> To slow this rise, Bellin Health System searched for innovative ways to reduce costs, while still improving availability and quality of care. The health care system developed and implemented the Total Health Model for its own workforce. Over the years, Bellin Health System slowed the growth of spending per employee through vigorous efforts aimed at improving efficiency.<sup>42</sup>

### Intervention

There are several components to the Total Health Model. The Bellin Health System: (1) uses health risks assessments and analysis of claims and productivity data to gain a better understanding of the health care needs of its employees, (2) offers comprehensive resources to help employees make sustainable lifestyle and behavior changes, such as providing health coaches, nutritionists, fitness experts, educational programs and support groups—all aligned with a primary care physician and medical home, (3) offers customized work solutions such as job matching, health and wellness services, ergonomics, workplace design, rehabilitation and case management and (4) provides a comprehensive navigation platform to guide patients and ensure they receive the appropriate level of care.<sup>43</sup>

### Results

Since 2002, the cost of employee health coverage at Bellin has not increased.<sup>44</sup> An estimated \$10 million savings in employee health costs was also projected over a five-year period.<sup>45</sup>

The success of the Total Health Model drew other organizations to follow. Several medium-sized companies contracted Bellin Health System to establish clinics at their workplace so that minor ailments and injuries among employees are managed before they become serious.<sup>46</sup> This type of prevention and promotion of healthy living has had a tremendous fiscal impact on organizations that adopted them. The Fincantieri Marine Group, for example, was able to reduce total health care spending by \$2 million even though its workforce has expanded.<sup>47</sup> Similarly, Northeast Wisconsin Technical College estimates saving about half a million dollars per year, and the Foth Companies are saving a quarter of a million dollars per year. In some places, the model is slowing down health care spending. At LaForce Inc., spending grew less than 2 percent on average annually over the last four years.<sup>48</sup>

### Lessons Learned

Engaging and investing in the health of employees, with their active participation, can have a significant impact on both parties: Employers benefit from reduced health care costs and spending while employees benefit from quality care and improved health and well-being.

[Bellin Health System](#)

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## **Mission: Health at Sentara Healthcare**

### **Sentara Healthcare**

Sentara Healthcare is a nonprofit health care system headquartered in Norfolk, Virginia. It consists of 10 acute care hospitals and operates more than 100 sites in Virginia and North Carolina.<sup>49</sup> Sentara Healthcare has 3,680 medical providers and three medical groups with 618 providers.<sup>50</sup>

### **Background**

Sentara Healthcare found that 20 percent of employees were responsible for 80 percent of the organization's health care costs.<sup>51</sup> Refusing to continually increase insurance co-payments and premiums among its employees, health care leaders at Sentara explored innovative ways to cut costs.<sup>52</sup>

### **Intervention**

In 2008, Sentara Healthcare in partnership with Optima Health—a sector of the former and its insurance carrier—established Mission: Health, an incentive-based wellness and disease management program. The program was developed to manage health care costs for more than 11,200 benefit-eligible employees in both the Virginia and North Carolina locations.<sup>53</sup> Nearly 80 percent of Sentara's employees participate in Mission: Health.<sup>54</sup>

Employees complete a voluntary health profile that measures their risk factors. Those identified as low-risk receive more than \$500 in annual premium reductions while those considered high-risk are given an opportunity to earn the award by partnering with a health coach.<sup>55</sup> Additional incentives are also available to employees with targeted chronic diseases such as diabetes, coronary artery disease or congestive heart failure, or those who are pregnant. They are awarded an extra \$450 if they partner with diseases managers who monitor their medications, check-ups and other crucial health activities.<sup>56</sup>

### **Results**

Both employers and employees benefit from the program. During the first year, not only did employees receive monetary rewards, 85 percent of participants who were identified as high-risk and monitored in the program maintained or improved their critical health risks.<sup>57</sup>

In 2010, Sentara Healthcare saved \$3.4 million in health care costs.<sup>58</sup> According to Michael M. Dudley, president and CEO of Optima Health, for every dollar spent to reward employees, the organization saved \$6.<sup>59</sup> In a more recent study, Sentara saved more than \$4 million in medical costs and sustained significant return on investment.<sup>60</sup> In addition, for every dollar invested in the program, Sentara saved \$2.70.<sup>61</sup>

### **Lessons Learned**

The Mission: Health program at Sentara Healthcare demonstrates that investing in workforce wellness is beneficial to employees and employer. The wellness incentive program engages employees to maintain or improve their health through monetary rewards while helping employers reduce health care spending and adapt to rising costs.

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## **WellnessWorks at Saint Elizabeth's Medical Center**

### **Saint Elizabeth's Medical Center**

Saint Elizabeth's Medical Center, part of Ministry Health Care, is a 25-bed critical access hospital located in Wabasha, Minnesota.

### **Background**

In 2003, Saint Elizabeth's Medical Center built a robust program, WellnessWorks, which includes a variety of wellness offerings for staff and family members. Its objectives were to create a culture of wellness, address high claims of utilization and serve as an example to the community.<sup>62</sup>

Seeing great value in workforce wellness, Saint Elizabeth's Medical Center began campaigning for similar programs in the community.<sup>63</sup> The medical center started collaborating with local businesses to provide wellness screening for their employees.<sup>64</sup>

### **Intervention**

The wellness program at Saint Elizabeth's Medical Center encouraged employee participation in activities that promote physical exertion and improve nutrition. This later expanded to a more robust initiative that includes an on-site family wellness center, biometric screening/health risk assessment, clinical consultation/coaching, tobacco cessation and nicotine replacement products, LEARN Healthy Lifestyle series, Medication Therapy Management, chronic disease management programs, healthy cafeteria options and an abundance of wellness education, activities and resources.<sup>65</sup>

In transforming the culture of health at Saint Elizabeth's Medical Center, the comprehensive wellness program catered to the needs of both high- and low-risk employees. In fact, it offered varying levels of participation based on health status and physical ability, ensuring a broad range of engagement in the workplace.

Many offerings of WellnessWorks are either free or discounted. In addition, the program provides monetary incentives to further encourage staff and family participation. For example, employees receive a \$50 reward for completing an annual physical, a yearly dental checkup, a flu shot and a biometric screening/consultation. They may also earn up to \$200 for completing tiered exercise and nutritional requirements.

### **Results**

Over time, participation rates grew and health status improved among individuals in the program. Early in 2011, Saint Elizabeth's Medical Center reported that more than 60 percent of its workforce is participating in on-site wellness programs and activities.<sup>66</sup> Many employees are also adopting healthy habits and reducing risk factors.<sup>67</sup> Over a five-year period, participants experienced 67 percent reduction in high-risk total cholesterol, 36 percent reduction in high-risk LDL cholesterol and 56 percent reduction in pre-diabetes.<sup>68</sup>

As the largest employer in the community, Saint Elizabeth's Medical has made its wellness efforts a paradigm for improving overall community health. The medical center is reaching out to local businesses, schools and other community organizations to share resources and knowledge.

### **Lessons Learned**

Financial constraints make it challenging for Saint Elizabeth's Medical Center to hire staff dedicated to coordinating the wellness program. As a result, wellness committee members took on various roles. Wellness committee members emphasize that gaining administrative support, integrating wellness



initiatives into the strategic plan and continually enhancing and improving services through employee feedback are necessary to retaining participation.<sup>69</sup>

Saint Elizabeth's Medical Center is a small, rural medical center, and it struggled to sustain cost savings since a small number of large claims—one or two—can have a significant impact on its small group market.<sup>70</sup> Through WellnessWorks, Saint Elizabeth's Medical Center found that it can reduce or at least maintain health care costs. According to Jim Root, vice president of human resources, investing in wellness can benefit the medical center up to \$6 in savings for every dollar spent in claims, absenteeism and lost productivity.<sup>71</sup>

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## Strategies at the Health Care Team Level

Throughout the care continuum, clinicians have the most face time with health care consumers and are in the unique position to expand engagement strategies. Hospitals and health care systems should institute policies that encourage clinician-patient partnerships and increase patient involvement in their own care planning. Promising mechanisms include bedside rounding, bedside change-of-shift reports, patient- and family-activated rapid response teams, and medication reconciliation.

### ***Patient- and Family-Centered Rounds at Cincinnati Children's Hospital Medical Center***

#### **Cincinnati Children's Hospital Medical Center**

Cincinnati Children's Hospital Medical Center (CCHMC) is an academic teaching hospital with 577 beds. In 2001, the institution began the Robert Wood Johnson Foundation's Pursuing Perfection initiative, which includes the development of an interdisciplinary group of patients and parents to redesign patient-centered care delivery.

#### **Background**

Families were historically not included in rounding or in supporting the providers who conducted rounds. Families did not witness the decision-making process for future treatments and rarely participated as a result.

#### **Intervention**

Family representatives suggested that parents attend teaching rounds to improve communication. CCHMC did not perfect the model right away, but started with smaller changes to the rounding system to improve communication and analyze results. Families were interviewed throughout the trial implementation to describe their experiences, and changes were incorporated as necessary. CCHMC also instituted a patient and family experience committee to address unsolicited patient and family concerns. The goal was to address concerns as they happened, such as a delay in the operating room schedule, and while the family was still in the hospital so staff could strengthen the lines of communication and mitigate negative perceptions and feedback as much as possible. The intervention focused on the entire inpatient population at CCHMC.

The bundle of interventions that comprise family-centered care at CCHMC includes (1) determining patient preference for family-centered rounds, (2) using a patient/family preference card, (3) standardizing the format for rounds that solicit parent concerns, (4) developing a plan of care for each patient, such as preparing daily goals and listing them on a board in the patient's room as well as the electronic medical record and (4) agreeing on discharge criteria in a manner that the family can comprehend. An important focus is that the nurse who is caring for the patient is in the room during the rounds. In this family-centered model, patients and families are benefiting from providers who are available to answer questions and concerns.

#### **Results**

CCHMC monitored feedback from all involved parties: nurses, residents, attending physicians and families. The process evolved based on this feedback, and within one year, family-focused teaching rounds were standard throughout the organization. CCHMC monitored patient and family satisfaction scores as well as anecdotal information from providers participating in the rounds to see where changes could be made.

## Lessons Learned

Families determine their preferred rounding process when their child is admitted (see sample card in Figure 2), with staff explaining the process and opportunities for their participation. Initially, patients and families were given cards upon admission to indicate their rounding preference. Realizing that patient and family perspectives related to rounding may change during the course of the hospital stay, many inpatient units now offer patients and families the opportunity every day to participate in the rounding process.

**Figure 2: Sample Blue (Patient/Family Preference) Card**

PATIENT/FAMILY PREFERENCE CARD

Patient/Parent Participation \_\_\_\_\_ Room # \_\_\_\_\_

Patient name: \_\_\_\_\_

☐ I (We) would like to document on the chart

☐ I (We) would not like to document on the chart

☐ Please include me (us) in rounds:

☐ In the hallway

☐ In the room

☐ Wake me up if I'm sleeping

☐ Please do not include me in rounds, but keep me (us) updated about my (our) child's health.

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## ***Patient- and Family-Centered Rounds at Helen DeVos Children's Hospital***

### **Helen DeVos Children's Hospital**

Helen DeVos Children's Hospital is a 212-bed children's hospital located in Grand Rapids, Michigan. The hospital examined its patient rounding process and decided it needed to become more family-centered.

### **Background**

Hospital leaders wanted the multidisciplinary team to engage the family and the patient and involve them in the decision-making process as well as help them participate in clinical readiness for discharge.

### **Intervention**

The hospital completely revised its procedure for rounding to include the patient and family as active participants in the day's care plan. The family became the center of the rounding process. The team now utilizes the families' input, values the information they provide and asks them to actively participate in making the care plan. The team prepares families for rounding. The staff advises families in advance about the size of the care team that will be rounding, describes what to expect and encourages them to ask questions and voice concerns. When families miss rounding, the care team attempts to return later in the day to keep the family engaged.

### **Results**

Patient and family rounds help empower families to have a trusting relationship with the health care team, increase their understanding of the care plan and create a safer culture for patient, family and staff. Since implementing family-centered rounds, nursing units have raised their patient satisfaction scores from below the 50th percentile to greater than the 90th percentile on a consistent basis. Although family-centered rounds may not be the only reason for these higher scores, families have responded positively about their involvement in rounds and feel better prepared for discharge.

### **Lessons Learned**

It is important for staff to remember that the patient's family knows the patient best and the team must have an open mind when making a plan of care. Families are very willing to tell the team that something is not the best choice, particularly in cases involving children with complex medical needs. Utilizing what the patient and family have to say and putting them at the forefront of decision making are paramount. Changing the rounding process was a new experience for the hospital's health care team. In the past, rounds were medically driven and included a lot of medical terminology that patients and families did not understand.

The team no longer uses medical jargon during rounds but instead tries to talk in a way that patients can understand. Medical education now occurs outside of the patient's room. This has been a culture shift for the team as well as the patients and families involved.<sup>72</sup>

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## **Shared Decision Making at Informed Medical Decisions Foundation**

### **Informed Medical Decisions Foundation**

Informed Medical Decisions Foundation (IMDF), founded in 1989 and based in Boston, Massachusetts, is a nonprofit organization working to advance research, policy and clinical models to ensure that patients understand their health care choices and have the information and support to make sound medical decisions.

### **Background**

IMDF supports research projects on shared decision making at both primary and specialty care demonstration sites across the United States. In addition, IMDF: (1) facilitates a learning community, (2) provides patient surveys to help evaluate decision aids and their impacts, (3) provides access to a secure online data warehouse to capture patient survey data and (4) performs data analyses on survey process measures.<sup>73</sup>

Currently, there are 10 demonstration sites representing a wide geography of rural and urban areas: a nationwide Breast Cancer Initiative, Dartmouth-Hitchcock Medical Center, MaineHealth, Massachusetts General Hospital, Mercy Clinics, Inc., Oregon Rural Practice-based Research Network, Palo Alto Medical Foundation, Stillwater Medical Group, University of California San Francisco Breast Care Center, and University of North Carolina at Chapel Hill. Each site consists of a variety of provider organizations serving a diverse patient population. Some sites are affiliated with large academic medical centers, and others are affiliated with independent community practices.

From the demonstration sites, a learning collaborative was formed. IMDF facilitated monthly calls so that members of the group could share implementation strategies—ideas, challenges and successes—on shared decision making. These teleconferences provide a platform for learning how to overcome barriers to successful implementation in real world clinical settings.

### **Intervention**

IMDF has developed several tools to facilitate the shared decision-making model at its demonstration sites. The decision aids are presented in the form of text, graphics, video, personal stories, and more. These tools provide patients with information about a specific condition, evidence organized around a specific decision, charts and graphs, and other tools, in an unbiased manner. The tools are aimed at encouraging patients to understand evidence in the context of their own goals and engage in decision making with their physicians. IMDF recognizes the need for physicians to put shared decision making into action and is in the process of creating a usable provider tool for clinicians. IMDF now offers six steps of shared decision making that are focused on provider actions: (1) invite patients to participate, (2) present all available options in simple, easy-to-understand language, (3) provide information on benefits and risks, (4) assist patients in evaluating options based on their goals/concerns, (5) facilitate deliberation and decision making and (6) assist with decision making.

### **Results**

According to the 2007 National Survey of Medical Decisions, participants who had made medical decisions reported talking more about why they might want to have a medical treatment than about why not to have the treatment. The findings suggest that patients are not getting balanced information about treatment options during discussions with providers.<sup>74</sup>

In 2011, a study published online by the Cochrane Database of Systematic Reviews examined the impact of decision aids. From 86 trials in six countries of 34 different types of decisions, the study found that decision aid tools led to greater knowledge, higher accuracy in risk perceptions, lower decisional

conflicts, higher participation in the decision making and fewer individuals that were undecided about their care.<sup>75</sup> In another implementation project that introduced the tools for some health conditions with treatment decisions that were also highly sensitive to patients' and physicians' preferences, decision aids were linked to reduced rates of elective surgery and lower costs.<sup>76</sup> At Group Health, where this research was conducted, there were 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements and 12 percent to 21 percent lower costs over a six-month period.<sup>77</sup>

### **Lessons Learned**

To make informed decisions, patients must have adequate knowledge and understanding of issues related to their care.<sup>78</sup> Essential elements to support shared decision making include improving knowledge about the risks, benefits and characteristics of medical procedures; and incorporating patients' values and preferences into the decisions.

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## ***Bedside Change-of-Shift Reporting at Emory Healthcare***

### **Emory Healthcare**

Emory Healthcare, a large academic teaching system in Atlanta, deployed a patient- and family-centered care transformation model in 2008.

### **Background**

In partnership with patients and their families, Emory nursing staff created a set of evidence-based guidelines on items nurses should discuss during shift changes at the bedside. Conducting change-of-shift reports at the bedside provides another opportunity for patients and families to become involved in the care team and participate in the mutual sharing of information to ensure that patient, family and team priorities are identified.

### **Intervention**

The goal of Emory's bedside change-of-shift reporting is to engage patients and their families as partners in goal setting, treatment decisions and education. Patient and family advisors helped develop and test the protocols with nurses. Outcome analysis revealed that patient satisfaction improved so much in intensive care units that bedside shift reporting was implemented throughout all acute care areas at four of the Emory hospitals. Patient and family advisors served as instructors to train all front-line clinical staff on the new initiative. Nurses received ongoing training and feedback when necessary and helped train new units that adopted the policy.

### **Results**

Patient satisfaction increased. Press Ganey satisfaction scores for overall nursing care increased from the 41st percentile to 78th percentile, and patients' ratings of how well nurses kept them informed increased from the 43rd to 80th percentile. While these increases cannot solely be attributed to the bedside change-of-shift reports, a 2011 survey of the Emory nursing staff showed that the measure of overall partnership was highest in units that used bedside shift reports. Quality outcomes also improved. Hospital-acquired pressure ulcers decreased from 8.15 percent to 2.5 percent, and patient falls decreased from 3.24 to 2.85 per 1,000 patient days.

### **Lessons Learned**

Bedside change-of-shift reporting enhanced the engagement of staff with patients and families.

[Emory Healthcare  
http://www.emoryhealthcare.org/](http://www.emoryhealthcare.org/)



## ***Flexible Visiting Hours at Atlantic Health System***

### **Atlantic Health System**

Atlantic Health System, New Jersey, owns and operates Morristown Medical Center, Overlook Medical Center, and Newton Medical Center. The three hospitals combined have 1,308 beds and more than 2,750 affiliated physicians. They provide a wide array of services and specialty areas including advanced cardiovascular care, pediatric medical and surgical specialties, neurology, orthopedics and sports medicine.

### **Background**

To further encourage patient and family engagement, visiting hour restrictions were eliminated at three New Jersey hospitals in the Atlantic Health System: Morristown Medical Center, Goryeb Children's Hospital, and Atlantic Rehabilitation Institute. The open visitation policy was crafted with input from administration, nursing, medical staff, trustees, security, and patients and families.

### **Intervention**

The new policy allowed for two visitors to be with a patient if both the patient and the floor nurse agreed that having visitors did not present any problems at that particular time. In the first five months of the open visitation policy, approximately 10,000 visitors came to the hospitals during the previously restricted time frames.

### **Results**

Patient satisfaction scores at the hospitals increased. An internal staff survey showed strong support for continuing the open visitation policy.

### **Lessons Learned**

Initial results from implementing the open visitation policy have been positive overall. With careful planning and policy implementation, the participating medical centers avoided much of the staff resistance toward unrestricted visiting hours.

(As of January 2013, a peer-reviewed journal article about Atlantic Health System's flexible visiting hours is pending.)

[Atlantic Health System](#)

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## ProvenHealth Navigation at Geisinger Health System

### Geisinger Health System

Geisinger Health System is an integrated health services organization that serves more than 2.6 million residents in 44 counties in both central and northeastern Pennsylvania.

### Background

With the care delivery system changing, Geisinger Health System began looking for ways to improve patient outcomes, quality of service and value of care. The organization's community practice service line—doctor's offices within the health care system—met and examined its structure and started discussing ways to provide higher value care to members and patients.<sup>79</sup> As a result, in 2006, Geisinger Health System and Geisinger Health Plan developed and established a medical home model, creating ProvenHealth Navigator.

ProvenHealth Navigator was designed to reduce downstream costs from the highest acuity by moving resources upstream.<sup>80</sup> In particular, more services are rendered in primary care as the starting point of the chain of care delivery. Successful upstream efforts are expected to reduce inpatient care costs and unnecessary duplication of service.<sup>81</sup>

### Intervention

The medical home model is built upon a five-point framework: patient-centered primary care, integrated population management, medical neighborhood, quality outcomes and value-based reimbursement.<sup>82</sup> With this framework, ProvenHealth Navigator “wraps a bundle of services around the patient and family and addresses healthy behaviors, disease prevention and disease management.”<sup>83</sup> These services include 24/7 phone access to a nurse care manager, same-day appointments and a primary-care office staff that facilitates access to community resources and helps patients understand medications and prescription coverage—all of which help decrease unnecessary hospitalizations.<sup>84</sup>

### Results

Geisinger's medical home model improved care coordination, enhanced patient access to primary care providers and provided more effective and efficient disease and case management. Additionally, studies show that ProvenHealth Navigator reduced costs over time. From November 2007 to December 2010, Geisinger's estimated total cumulative savings was 7.1 percent (based on the model that accounts for the prescription drug coverage interaction effects) and 4.3 percent (based on the model that does not account for the interaction effects).<sup>85</sup>

### Lessons Learned

Although it takes time to reap benefits from the redesign of care, cost savings are achievable.<sup>86</sup>

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## Strategies at the Individual Level

With the growth of health information technology and the use of social media, health care organizations are testing promising approaches to engage directly with individual patients to support information sharing, shared decision making and self-care. In some instances, individual patients are driving this change.

### *Use of Personal Health Records at Howard University Hospital*

#### **Howard University Hospital**

Howard University Hospital is a private, nonprofit teaching hospital located in Washington, D.C.

#### **Background**

Fragmented care and changes in insurance plans, especially for the Medicaid population, prompted the leadership of Howard University Hospital to develop a program that gives patients access to an electronic personal health record and improves continuity of care.

#### **Intervention**

Howard University Hospital provided patients in its diabetes program with a free electronic personal health record (PHR), linked to the electronic medical record, to help them monitor a range of clinical indicators important to a diabetic's health, including blood sugar and weight. Clinicians are also able to check how their patients are doing and follow up with them between visits. Patients are invited to enroll in the program and get assistance setting up the PHR, with training and ongoing support.

#### **Results**

The program increased patient engagement, especially for patients with Medicaid insurance. Hemoglobin A1c levels fell by approximately 13 percent for patients participating in the program, compared to an increase in levels for those not participating.

#### **Lessons Learned**

Patients are more apt to use the program if clinicians use the data during visits with their patients. In addition, it is important to remove any barriers for use by patients, including making it easy for them to obtain passwords.

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## **Patient-Driven Care at Ryhov Hospital**

### **Ryhov Hospital**

Ryhov Hospital is a county hospital in Jönköping, Sweden, with a dialysis unit for patients with renal disease.

### **Background**

Ryhov Hospital transitioned more than 52 percent of its traditional peritoneal and hemodialysis patients to a self-management program for patients undergoing dialysis. This change in approach was driven by a single patient seeking to take charge of his own care and improve his quality of life.

### **Intervention**

A patient on dialysis at the hospital asked to learn how to perform self-dialysis. In response to this request, a nurse at Ryhov Hospital taught the patient how to use the dialysis machine, interpret lab values and document his care at the dialysis protocol. Shortly afterward, the patient was managing his own dialysis and experiencing fewer side effects of the treatment, such as nausea, edema and hypotension. The patient and the nursing staff took this success to the next level and began training other dialysis patients interested in self-dialysis. Patients document their blood pressure, weight, dryweight, blood flow, dialysis flow, symptoms, amount of water drawn, etc. on a report form, and the doctor or nurse enters their information in the record system.

### **Results**

Currently 52 percent of Ryhov Hospital's dialysis patients are on self-dialysis. With the reduction in side effects from self-dialysis, patients have dialysis more often and infection rates have declined.

### **Lessons Learned**

Responding to the preferences of patients and engaging them as full partners in care can result in better outcomes, fewer complications and increased patient and caregiver satisfaction.<sup>87</sup>

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## The Future of Health Care User Engagement

While there is a tremendous need to bridge the gap between consumers, health professionals and policymakers to increase health care user engagement, the case studies in this report demonstrate a collective awareness for change. Many hospitals and health care systems across the United States and in other countries have deployed engagement initiatives and implemented best practices with impressive results. Engaging consumers in health care is essential for transformation of the care system. As the case studies illustrate, health care user engagement requires a collaborative partnership and relationship among all stakeholders, including patients, families, communities, providers and other individuals involved in the health care industry.

The health care system is adapting to the ever-changing needs and demands of health care users. As the health care system evolves and user engagement matures, opportunities are created to dramatically improve health care delivery. Many promising technologies and practices are being tested, and many are yet to be discovered.

This report discusses many issues related to health care user engagement, but other emerging areas deserve appropriate attention. Though not discussed in as much detail in this report, these other topic areas are likely to have some significance in the future of health care user engagement, but they require further research to address questions surrounding them. These topic areas include:

- Consideration and integration of behavioral health and mental health as it relates to engagement at all four levels—community, organization, team and individual
- Health plans and their role as significant stakeholders in the engagement process
- Role of employers as drivers for creating a culture of health
- Current and emerging technologies that will facilitate patient, family and provider interactions; health education; treatments and overall engagement
- Social media and its role as a means to enhance communication and networking with individual and communities

### Integration of Behavioral Health and Mental Health

Many health care professionals believe that people with serious mental illnesses have such impaired judgment or delusional beliefs that they cannot participate in making decisions about their own care and treatment.<sup>88</sup> Studies illustrate that many and perhaps most individuals with mental illnesses and their families can and want to participate in the decision making.<sup>89 90</sup>

Several strategies that cater to the needs and wishes of mental health care users have been developed and implemented. One study demonstrated that integrated care programs that place a mental health specialist in primary care settings have higher levels of patient engagement and comparable clinical results and overall costs.<sup>91</sup>

Experts in the integration of primary care and behavioral health have emphasized the importance of a “warm handoff.” “Warm handoff” is the transition from the primary care provider to the behavioral health consultant. The PCP activates and engages patients with special needs by personally introducing them to the behavioral counselor to establish an initial rapport. As a result, this process increases the likelihood that the patient engages in behavioral health treatment.<sup>92</sup>

## Consumer-Centered Health Plans

In the past, health plans have taken a one-size-fits-all approach—that is, a provider-centered strategy to communicate information to individuals.<sup>93</sup> But over the years, health plans have begun to recognize the value of improving patient engagement, acknowledging that “increased compliance helps them save money and that the investment in reaching consumers the right way is more than offset by improving levels of engagement.”<sup>94</sup>

In an effort to move away from this one-size-fits-all approach, some health plans are using the Patient Activation Measure (PAM) developed by Judith Hibbard, DrPH, a professor of health policy at the University of Oregon. The 13-question survey evaluates patients’ levels of engagement and measures their knowledge, skills, beliefs and confidence in managing their own health and care.<sup>95</sup> Using this measure, health plans are able to partner with and meet their members where they are on the engagement spectrum, helping them become better managers of their own health and effective health care users.

Among those already using the Patient Activation Measure is Medica, a regional health plan in Minneapolis with more than 1.6 million members.<sup>96</sup> Medica has reported saving \$19 to \$22 per month from each member in comparison with costs for the controls.<sup>97</sup> Regence BlueCross BlueShield, which has 2.2 million members in Oregon, Utah, Idaho and parts of Washington, also plans to use PAM later this year.<sup>98</sup> According to Ralph Prows, MD, chief medical officer at Regence BlueCross BlueShield, the organization is interested in using PAM as a yardstick for its programs, tools and techniques to measure and evaluate how patients are engaging with their doctors.<sup>99</sup>

Other efforts are also underway to engage health care users in controlling health care costs. Some health plans are providing financial rewards to members who are choosing low-cost providers. Both Harvard Pilgrim Health Care and at least three plans affiliated with Anthem have implemented monetary incentives to draw the attention of members.<sup>100</sup> As a result, the SaveOn program of HPHC increased the volume of its most cost-efficient providers while the Compass SmartShopper program of Anthem was able to target high-volume elective procedures.<sup>101</sup>

Consumer-centered health plans demonstrate that engagement is a two-way stream that benefits both health care users and providers. With financial incentives, as seen in HPHC and the Anthem network, health care users become active participants in their care by being cognizant of the services they are receiving. By engaging members, health plans are able to control spending while rewarding members.

## Culture of Health: Employer Wellness Programs

According to the Value-Based Health Care Baseline Benchmarking Survey, “a majority of multiemployer funds and public employers have realized the importance of sponsoring health management initiatives such as wellness and disease management programs that are at the core of a value-based health care system.”<sup>102</sup> In the next two years, the survey projected that both multiemployer funds and public employer sectors will likely increase their emphasis on these areas because, when implemented together, wellness programs improve the health of employees, enhance their quality of life and lead to a culture of health within their organizations.<sup>103</sup>

Because public and private sector employers have unique characteristics, their strategies must be tailored according to the different barriers in their organizations. Among these challenges are dispersed worker populations and the lack of employee engagement and sufficient financial incentives.<sup>104</sup> But despite challenges, these organizations are not only realizing the need to change but also are increasing their focus on value-based health care.<sup>105</sup>



## Emerging and Present Technology

### Telemedicine

With technology expanding, some health care providers are now using online applications to interact with patients. Examples are Skype and California LiveVisit, a web-based telemedicine application that offers a secure platform for face-to-face and patient-to-provider visits. These video chat services are convenient for both health care users and providers because they allow for quick check-ins and follow-ups. This type of distant interaction encourages patients to stay at home while in recovery rather than spread contagious diseases, if any. In addition, providers, especially specialty physicians, are able to reach out and provide consultations to patients in a distant or remote location.

### Online Patient Records

In a study—involving 105 physicians and 13,564 patients—conducted at Beth Israel Deaconess Medical Center, Geisinger Health System, and Harborview Medical Center, researchers found that patients were enthusiastic when provided access to their doctors' notes via a secure Internet portal.<sup>106</sup> A large majority of individuals accessed some or all of their doctors' notes and almost 90 percent believed that having this access would affect their decisions when seeking future care.<sup>107</sup> The Web proved to be an effective platform to expand transparency of medical records to patients. At the study's completion, 99 percent of patients at all three hospitals continued to access their visit notes, and none of the participating physicians elected to end this practice.

### Online Health Resources

Not only does the Internet contain a plethora of information, it also serves as a valuable resource for engaging health care users. WebMD, for example, is a rich repository of health and science information. It provides patients with reliable medical knowledge that was previously unavailable to them, mainly due to their inability to acquire or discuss the information with a provider. Additionally, the website allows for active participation among health care users, through online blogging with research scientists and medical and public health experts.

### Patient Engagement Systems

To engage patients, some hospitals are using televisions at the bedside to deliver information pertaining to their individual care. This practice has resulted in better patient outcomes, efficiency in the workflow of health care professionals and other hospital staff, and improved scores in patient satisfaction surveys.<sup>108</sup>

Several hospitals and health care systems are now using patient engagement systems. LodgeNet's interactive e-suite system at NorthShore University HealthSystem allows patients to view preoperative videos at home, see their daily schedule when in the hospital and review home care instructions after discharge.<sup>109</sup> PCH is an interactive TV channel designed to answer common questions and reduce anxiety during treatment for patients in Phoenix Children's Hospital.<sup>110</sup> CareNavigator at Skylight Health Care Systems reinforces direct clinical care and has been a significant tool in reducing the amount of time nurses spend educating their patients.<sup>111</sup> GetWellNetwork, an interactive patient care system used at the University of Minnesota Amplatz Children's Hospital, engages patients by overlaying content on top of whatever channel the patient is watching, so they can respond quickly and easily to automated prompts.<sup>112</sup>

Collaboratively engaging patients, families and communities has the potential to be a “game changer” in the transformation of the health care system in our country. Hospitals and health care systems can serve as laboratories for developing, testing, learning and disseminating new engagement practices. The impact of the practice of health care user engagement and the role that hospitals can play in leading this transformative element of system redesign in their own communities are foundational for achieving the Triple Aim in health care.



## Appendix: Center for Advancing Health Engagement Behavior Framework

### 1. Find Safe, Decent Care

- Find provider(s) who meet personal criteria (e.g., performance, cost, geographic access, personal style), will take new patients and accept personal insurance
- Use available comparative performance information (including cost data) to identify prospective providers
- Establish a relationship with a health care professional or group
- Use available comparative performance information (including cost data) to identify prospective health care facilities
- Seek and use the appropriate health care setting when professional attention is required

### 2. Communicate with Health Care Professionals

- Prepare in advance of outpatient and inpatient contact a list of questions/issues for discussion with the health care professional
- Bring list of all current medications (including supplements and alternative products) and be prepared to discuss their benefits and side effects
- Report accurately on the history and current status of physical and mental symptoms
- Ask questions when any explanations or next steps are not clear and express any concerns about recommendations or care experiences

### 3. Organize Health Care

- Make appointments; inquire about no-show policies; arrive on time
- Assess whether facility can accommodate unique needs (e.g., physical navigation, hearing or visual impairment, translation services) and arrange for assistance
- Bring documentation of health insurance coverage
- Bring another person to assist patient if frail, confused, unable to move around or unable to remember the conversation with the provider
- Bring a summary of medical history, current health status and recent test results to visits as appropriate
- Ensure that relevant medical information is conveyed between providers and institutions
- Obtain all test results and appointment records and maintain personal health record

### 4. Pay for Health Care

- Compare insurance coverage options, match to personal values, needs and preferences, and select coverage
- Gather and submit relevant eligibility documentation if applying for or seeking to maintain public insurance (e.g., Medicaid, Medicare, SCHIP), compare coverage options if applicable, match to patient's own values, needs and preferences, and select coverage
- Before seeking treatment: ascertain cost, benefit coverage restrictions and incentives such as mental health benefits limitations, pre-certification requirements, access restrictions to specialists or adjunct health providers, variables in co-pays for specific types of care or providers
- Maintain or adjust coverage in the event of unemployment, eligibility or family status changes (i.e., change of job, marriage, divorce, birth of child)
- Maintain all receipts for drugs, devices and services; submit any documentation of services and/or payments upon request or as needed for third-party payers (e.g., private insurance, medical/flexible health savings accounts or public payers) and submit payment; negotiate schedule and amount if necessary

## **5. Make Good Treatment Decisions**

- Gather additional expert opinions on any serious diagnosis prior to beginning any course of treatment
- Ask about the evidence for the efficacy of recommended treatment options (risks and benefits)
- Evaluate treatment options
- Negotiate a treatment plan with the provider(s)

## **6. Participate in Treatment**

- Learn about any newly prescribed medications and devices including possible side effects or interactions with existing medications and devices
- Fill or refill prescriptions on time, monitor medication effectiveness and consult with prescribing clinician before discontinuing use
- Maintain devices
- Evaluate and receive recommended diagnostic/follow-up tests in discussion with health care providers
- Monitor symptoms/condition including danger signs that require urgent attention (e.g., for diabetes—monitor glucose regularly, check feet; for depression—provide medication and/or counseling and monitor symptoms; for hypertension—measure blood pressure regularly, maintain blood pressure diary)

## **7. Promote Health**

- Set priorities for changing behavior to optimize health and prevent disease and act on them
- Identify and secure services that support changing behavior to maximize health and functioning and maintain those changes over time
- Manage symptoms by following treatment plans, including diet, exercise and substance use, agreed upon by the patient and his or her provider

## **8. Get Preventive Health Care**

- Evaluate recommend screening tests in discussion with health care provider
- Act on referrals for early detection screenings (e.g., breast cancer, colon cancer) and follow up on positive findings
- Get recommended vaccines and participate in community-offered screening/wellness activities as appropriate

## **9. Plan for the End of Life**

- Complete advance directives and medical power of attorney, file with personal/home records
- Discuss with/deliver to family physician and other health care providers, appropriate family and/or significant others
- Review documents annually; update and distribute as needed

## **10. Seek Health Knowledge**

- Assess personal risks for poor health, disease and injury and seek knowledge about maintaining health and caring for one's self
- If diagnosed with a chronic disease, understand the condition(s), the risks and benefits of treatment options and personal behavior change(s) by seeking opportunities to improve health/disease knowledge
- Know personal health targets (e.g., target blood pressure) and what to do to meet them

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