Engaging Consumers To Improve Outcomes: Bringing Patient Engagement To Population Health

The 2016 OPEN MINDS Strategy & Innovation Institute
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I. Patient Engagement In Health Care

II. Trends In Patient Engagement & Why It’s Important
   • Nicole Schechter, Psy.D., Rehabilitation Psychologist, Division of Rehabilitation Psychology and Neuropsychology, Department of Physical Medicine and Rehabilitation, Johns Hopkins School of Medicine

III. How Integration & Other Changes In The Health Care Landscape Are Affecting Patient Engagement
   • Nancy Ruddy, Ph.D., Vice President, Patient Engagement, McCann Health, & Principal, Nancy Ruddy, Ph.D., LLC

IV. Engaging Consumers In A Value-Based Market
   • Carole Taylor, RN, MSN, Chief Clinical Officer, Community Care

V. Questions & Discussion
Consumer Engagement In Health Care
What Is Patient Engagement In Health Care?

Consumers becoming better informed and more directly and proactively involved in decisions that affect their health.

“Patient activation” refers to a patient’s knowledge, skills, ability, and willingness to manage his or her own health and care.
Engagement Matters In A Value-Based Market

Studies show that consumers who are engaged in their care have lower health care costs and better outcomes.

- Consumers who are the least engaged have health costs averaging between 8% and 21% higher than consumers who are highly engaged in their care.

- Patient engagement can result in improved outcomes:
  - Better medication adherence
  - Reduced utilization of emergency departments
  - Reduced readmission rates
How Do You Engage Consumers In A Value-Based Market?

- Know your consumers – different consumers have different needs and approaches need to be customized
- Assist with care coordination and access - the health care system is complex and difficult to navigate
- Make them part of the care coordination team and give them options - consumers want to be involved in their care and part of the decisionmaking process
- Utilize technology – remote monitoring and communication tech (phone calls, email, texts, smartphone apps) can enhance engagement efforts
Nicole Schechter, Psy.D.
Rehabilitation Psychologist, Division of Rehabilitation Psychology and Neuropsychology, Department of Physical Medicine and Rehabilitation, Johns Hopkins School of Medicine
Patient Engagement: Tool for Improving Patient Outcomes

Nicole E. Schechter, Psy.D.
Dept. of Physical Medicine and Rehabilitation
Johns Hopkins University School of Medicine
Johns Hopkins Health Care
Acknowledgements and Disclosures

• Partners at Johns Hopkins: Susan Donovan, Teresa Eyer, Michelle Hawkins, Carlessia Hussein, Tracy Novak, Laura Torres, Stephen Wegener

• Thanks to students and colleagues, and more importantly, patients and families who have supported and inspired this work.

• Support in part from Centers for Medicare & Medicaid Services

• No relevant disclosures.
Since ancient Greek writings there have been three basic tools of medicine—
the herb, the knife and the word.

(Grant, 1995)
Changing Health Care Environment

• Changing health care problems

• Increased demands on patients, families and providers

• Increasing focus on quality indicators - patient satisfaction - and change in reimbursement - pay for quality
Crossing the Quality Chasm: Institute of Medicine

- Recognizes patients are the central health care workers. This work is untrained, unpaid and unacknowledged.

- Trains providers to help patients become active participants in their own care.
Chronic Care Model  (Wagner et al 1996)

Community
Resources and Policies
Self-Management Support

Health System
Health Care Organization
Delivery System Design
Decision Support
Clinical Information Systems

Improved Outcomes
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team

Improved Outcomes
Focus on Value-Based Health Care
(Berwick, 2013)

- Reimbursement based on how well health care services perform & positive patient outcomes
- Health delivery system reform
  - Continuity of Care
  - Training in communication & teamwork
  - Roles for non-physicians
- Prevention

An Unrelenting Call for Patient Engagement

- Chronic Care Model (Wagner, 1996)
- Crossing the Quality Chasm (Institute of Medicine, 2001)
- Value Based Health Care— (Berwick, 2011)
- Patient Activation Measure— (Hibbard, 2004)
- Shared Decision Making – (Charles, Gafni, & Whelan, 1997)
- Multidimensional framework for patient and family engagement in health and health care — (Carmane et al., 2016)
Shared Decision Making Principles

- Relationship built between patient & provider
- Discussion of all options – both parties share information
- Elicit thoughts from the patient about how to move forward (decision)
- Hope for agreement between patient & provider on decision
## Patient Activation

### Exhibit 2

**Predicted Per Capita Costs of Patients by Patient Activation Level**

<table>
<thead>
<tr>
<th>2010 Patient Activation Level</th>
<th>Predicted Per Capita Billed Costs ($)</th>
<th>Ratio of Predicted Costs Relative to Level 4 PAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 (lowest)</td>
<td>966**</td>
<td>1.21**</td>
</tr>
<tr>
<td>Level 2</td>
<td>840</td>
<td>1.05</td>
</tr>
<tr>
<td>Level 3</td>
<td>783</td>
<td>0.97</td>
</tr>
<tr>
<td>Level 4 (highest)</td>
<td>799</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Source** Judith H. Hibbard, Jessica Greene, and Valerie Overton, “Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients’ Scores,” *Health Affairs* 32, no. 2 (2013): 216–22. **Notes** Authors’ analysis of Fairview Health Services billing and electronic health record data, January–June 2011. Inpatient and pharmacy costs were not included. PAM is Patient Activation Measure. **p < 0.05**
EXHIBIT 1

A Multidimensional Framework for Patient and Family Engagement in Health and Health Care

Levels of engagement

**Direct care**
- Consultation: Patients receive information about a diagnosis
- Involvement: Patients are asked about their preferences in treatment plan
- Partnership and shared leadership: Treatment decisions are made based on patients’ preferences, medical evidence, and clinical judgment

**Organizational design and governance**
- Consultation: Organization surveys patients about their care experiences
- Involvement: Hospital involves patients as advisers or advisory council members
- Partnership and shared leadership: Patients co-lead hospital safety and quality improvement committees

**Policy making**
- Consultation: Public agency conducts focus groups with patients to ask opinions about a health care issue
- Involvement: Patients’ recommendations about research priorities are used by public agency to make funding decisions
- Partnership and shared leadership: Patients have equal representation on agency committees that makes decisions about how to allocate resources to health programs

Factors influencing engagement:
- **Patient** (beliefs about patient role, health literacy, education)
- **Organization** (policies and practices, culture)
- **Society** (social norms, regulations, policy)


http://www.healthaffairs.org/healthpolicybriefs/
Provider Barriers to Patient Engagement

- Low priority - if providers hold on to older models of care
- Competing priorities – EMR, safety, infection control
- Lack of incentives - this is changing
- Insufficient training – only recently included in medical school curricula
Johns Hopkins Medicine Overview

- Nonprofit

- Opened in 1889 with a tripartite mission: research, teaching & provision of medical services

- Operates six academic and community hospitals, four suburban health care and surgery centers

- More than 2.8 million outpatient & 115,000 inpatient encounters per year
Johns Hopkins Medicine Overview

- Employs more than 41,000 full-time faculty and staff, making it among Maryland’s largest private employers and the largest in Baltimore City.

- Receives $420 million federal funding annually.

- Ranked #1 in the nation by U.S. News & World Report for 22 years of the survey’s 26 year history.
What is the Johns Hopkins Model for Patient Engagement Training?

Refined the principles and skill set of Motivational Interviewing and combined with communication science to create Patient Engagement Training
What is the Johns Hopkins Model for Patient Engagement Training?

- Evidenced based approach shown to change behaviors and increase engagement in many patient populations
- Can be integrated into current practice as it can be done in a time efficient manner
- We do not ask providers to spend more time with patients – rather use the time more strategically
- Can be taught to a wide range of providers
- Can be used with any patient
- Can assist in improving patient satisfaction
Guiding Patient Engagement Training Principles

- Trainers are clinicians
- Respect clinicians wisdom
- Learn by doing – practicing the skills is vital
- Multimodal learning
- Maintenance program is vital and must fit organically within the structure of the organization – cannot add more meetings
- Monitor and provide feedback on skills after training
JHM Patient Engagement Training 3 Phases

Phase 1 – Planning Phase

Phase 2 – Initial Training

Phase 3 – Skill Building and Maintenance
Phase 1 - Planning

• Clarify specific needs of the clinical unit with the leadership

• Identify logistical issues, potential barriers and metrics with the leadership

• Collaboratively develop goals for the training

• Identify Patient Engagement champions who will be responsible for maintenance activities
Phase 2 – Initial Training

• 60 minute grand rounds for full staff, including office staff and all clinicians

• 4 to 7 hour basic training for clinicians
  • Incorporates lecture, videos modeling principles/skills, paired & triad & small group practice

• 1 hour additional training for PET champions
Phase 3 – Skill Building and Maintenance

• PET champion develops a maintenance plan to use with their team
  • Monthly or quarterly PET activities that serve as boosters for initial training
  • Champion receives coaching and monitoring of plan implementation – quarterly and as needed
• PET Tip of the Month
• Assessment of PET skills semi-annually
Evaluation Model

Learner Metrics

• Satisfaction with training
• Self-efficacy for using patient engagement skills & principles
• Knowledge & attitudes
• Behavioral measure of effective utilization of skills

Patient Metrics

• Health care & provider satisfaction scores
• Cancellation rates
• Hospital admissions for preventable complications
To learn more about PET- nschech1@jhmi.edu
Nancy Ruddy, Ph.D.
Vice President, Patient Engagement, McCann Health, & Principal, Nancy Ruddy, Ph.D., LLC
The 7 “C’s” of Health Care Engagement

Strategies and Techniques to Create an Engaged Care Environment for Patients and Health Care Providers

Nancy Breen Ruddy, Ph.D.
nruddyphd@gmail.com
Two Roles, One Mission

McCann Health

- Help patients understand condition, role of pharmaceutical product in management
- Help pharma companies understand
  - the patient and family perspective, facilitate patient centricity
  - multi-system impacts on health

IPC & Health Communication Consultation

- Help health systems
  - evaluate readiness for IPC
  - Select sites and staff for pilots
  - Conduct training for new model
  - Manage systemic issues
- Coach health providers
  - Shared decision making
  - Communication skills
  - Self care
Patient Engagement & Provider Engagement
COLLABORATION
COLLABORATION

- Team huddles
- Integrated behavioral health and social services
- Streamlined interprofessional communication
- Ensure all training is interprofessional

- Give patients & families multiple ways to vent frustrations - highlight when patient feedback has lead to change
- “Baseline knowledge” dialogue initiation training
- Emphasize shared decision making
WHAT IS INTEGRATED PRIMARY CARE?

...combines medical and behavioral health services for problems patients bring to primary care, including stress-linked physical symptoms, maladaptive health behaviors, and/or mental health or substance misuse concerns and disorders. ¹²,³

For any problem, patients have come to the right place... no wrong door
<table>
<thead>
<tr>
<th>TRADITIONAL MENTAL HEALTH</th>
<th>INTEGRATED PRIMARY CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided outside primary care</td>
<td>Services on-site in primary care</td>
</tr>
<tr>
<td>Patient must find and then access services</td>
<td>Services often offered in “real time”</td>
</tr>
<tr>
<td>Siloed healthcare professionals</td>
<td>Interdisciplinary team</td>
</tr>
<tr>
<td>Referral occurs after symptoms affect functioning</td>
<td>Opportunity for prevention and early intervention</td>
</tr>
<tr>
<td>Tendency toward longer treatment</td>
<td>Brief interventions</td>
</tr>
<tr>
<td>Mental health focus only</td>
<td>Focus on health behaviors, mental health concerns, and substance misuse</td>
</tr>
</tbody>
</table>
Keys to Success

• Appropriate practice selection
  • Readiness to change
  • Appropriate patient population
  • Biopsychosocial orientation

• Systemic alignment
  • EHR
  • Payment

• Work flow evolution
  • Screening
  • Warm hand offs
  • Mental health providers as team members

• Specialty mental health and addiction treatment back up
The biggest KEY? TRAINING

• Prior to integration
  • Engage providers to see value of IPC
  • NEW skill set for mental health providers
  • Collaboration and communication skills
  • Teach medical providers how to triage and refer

• Starting IPC
  • Site visits, focus on team based care
  • Shadowing
  • Clinical and administrative consultation for MH
  • Implement screening and referral protocols

• Evolving IPC
  • Evaluate and evolve screening and referral protocols
  • Site visits, focused on “co-location creep”
  • Patient education and engagement in model of care
• Educate providers about health literacy
• Dispel myths about comprehension
• Seek comprehension “champions” to monitor ongoing efforts
• Recognize impact of time constraints

• Ensure all patient facing materials are health literate
• Use teach back technique
• Consider expanding role of health educators, either in person or virtually
• Multi-sensory instructions
Edgar Dale: “Cone of Experience”

What we remember,

- Of what we read: 10%
- Of what we hear: 20%
- Of what we see: 30%
- Of what we see and hear: 50%
- Of what we say: 70%
- Of what we say and do: 90%

Most patient education is passive information dissemination.

Passive

Active

45
Applying Best Practices of Patient-Centered Design

- Appealing: Demonstrating empathy in look, feel, and language
- Relevant: Focusing on patient needs and situation in the patient experience
- Usable: Designing with context of use and patient limitations in mind
- Learnable: Considering differences in cognitive abilities, pacing, and learning styles
- Easy to Act On: Guiding toward next steps and supporting behavior change
- Demonstrating empathy in look, feel, and language
CONTEXTUALIZATION
CONTEXUALIZATION

• Team huddles
• Integrated behavioral and social services
• Social history as part of medical history
• Emphasizing the “why” with the “what”

• Normalize the struggle of managing illness
• Family dialogue, family meetings
• Engage social supports
• Explore health beliefs
COMMUNITY
COMMUNITY

Team huddles
Social relationships
Support connection to professional discipline
Integrated behavioral health and social services

- Engage social support networks
- Group Medical Appointments
- Connect to advocacy groups
- Connect to live and virtual support groups
CONTINUITY
• Emphasize how continuity supports efficiency
• Teach support staff to negotiate with patients re: continuity
• Attend to continuity indices, provider patterns
• Streamline communication

• Educate patients about role of continuity in optimal care
• Ensure patients know WHO is on team and role of each provider
CONNECTION
CONNECTION

- Team huddles
- Support ongoing learning
- Peer supervision beyond M&M
- Recognize best practices

- Peer patient navigators
- Group medical appointments
- Connect to advocacy groups
- Ensure patients know WHO is on their team, and role of each provider
COMPASSION
• Imbed self care into training and daily team functioning
• Recognize the impact of daily hassles on ability to show compassion
• Encourage team members to give feedback on patient interactions

• Build providers’ empathy skill set
• Encourage patients to process emotional reactions to illness with providers and family
• Normalize emotional challenges of illness in materials
Nancy B. Ruddy, Ph.D.
Clinical Psychologist

Specializes in:

Integrated Primary Care
Provider Communication Coaching
Complex Patient Programming and Management
Patient Engagement
Medical Family Therapy & Health Psychology

nruddyphd@gmail.com
Member Engagement: Recovery and Wellness Opportunities

Carole Taylor, MSN, RN
Chief Clinical Officer
About Community Care

• 501(c)(3) not for profit behavioral health managed care organization; licensed by Department of Insurance
  – 900,000+ Medicaid members in 39 of 67 PA counties
  – Behavioral health only
  – Part of the UPMC Insurance Division
• NCQA and URAC accreditation/certification
• 630 staff in 10 offices across PA; corporate office in Pittsburgh, PA
• Experience with full-risk, shared-risk, and Administrative Services Only (ASO) contracts
• Recipient of 2 PCORI Grants
## Membership and Revenue Growth

### Community Care Behavioral Health

<table>
<thead>
<tr>
<th>Year</th>
<th>DHS Capitated Revenue (in thousands)</th>
<th>Covered Lives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$77,066</td>
<td>122,314</td>
</tr>
<tr>
<td>2002</td>
<td>$175,655</td>
<td>189,177</td>
</tr>
<tr>
<td>2004</td>
<td>$279,629</td>
<td>243,297</td>
</tr>
<tr>
<td>2007</td>
<td>$685,277</td>
<td>526,759</td>
</tr>
<tr>
<td>2011</td>
<td>$955,303</td>
<td>667,579</td>
</tr>
<tr>
<td>2014</td>
<td>$987,967</td>
<td>739,693</td>
</tr>
<tr>
<td>2015</td>
<td>$1,049,280</td>
<td>908,150</td>
</tr>
</tbody>
</table>
Recovery and Wellness of the Member

Improving the Well-Being of the Individual and the Community

- Recovery Transformation
- Peer & Family Involvement
- Respecting Individual Differences
- Physical & Behavioral Health Integration
- Systems Integration (Children & Youth)
- Focused Care Management Model

Person with Lived Experience
Dimensions of Wellness

**EMOTIONAL**
Coping effectively with life and creating satisfying relationships

**ENVIRONMENTAL**
Good health by occupying pleasant, stimulating environments that support well-being

**INTELLECTUAL**
Recognizing creative abilities and finding ways to expand knowledge and skills

**PHYSICAL**
Recognizing the need for physical activity, diet, sleep, and nutrition

**FINANCIAL**
Satisfaction with current and future financial situations

**SOCIAL**
Developing a sense of connection, belonging, and a well-developed support system

**SPIRITUAL**
Expanding our sense of purpose and meaning in life

**OCCUPATIONAL**
Personal satisfaction and enrichment derived from one’s work

**WELLNESS**

SAMHSA
Engaging Members to Enhance Value in a Recovery Focused Behavioral Health Framework
Programs:

- High Risk Intervention for Members with SMI
- Integrated Community Teams
- Decision Support Centers based on CommonGround®
High Risk Intervention Overview

- Data to define “Population” at risk
- Readmissions within 30 days
- Licensed care managers complete face to face “dialogue” with an individual during an inpatient stay within 48 hours of admission.
- Review social determinants leading to readmission with “targeted” interview.
- Use of Recovery Principles within the interview.
- Implementation of plan as to how the individual may avoid future ED visits and inpatient stay.
- Work with the treatment team to ensure adequate follow up.
Outcomes of Interviews

- The 30-day readmission rate for individuals receiving the interview was 37% lower than the readmission rate for individuals in the non-intervention comparison group, $p < .001$
Community Team Overview

- **UPMC Health Plan Community Team (CT)**
  - Provides intensive care management in the member’s home and other community settings for those health plan members who have been identified as having high costs and high utilization and indicators that these are related to behavioral or other psychosocial conditions

- **Aim of the program**
  - Reduce thirty day readmission rates, inpatient utilization rates, and total cost of care for members that have a history of utilization of inpatient services
Community Team Outcomes

- There was a statistically significant decline in the readmission rate.
- Follow up with PCP post intervention 79%
CommonGround and Decision Support Centers Overview (PCORI)

- Compare the effectiveness of two technology-driven interventions focused on patient-prescriber interactions around medication treatment to **increase patient activation and engagement in care and improve patient health status**.

**Measurement Based Care**
Standardized measurement of symptoms and side effects helps prescribers to target medications more specifically and track progress over time.

**Person Centered Care**
Prior to appointment, the patient uses peer support and software to prepare to participate in making shared decisions with the prescriber about next steps in treatment and recovery.

**Enhancing patient and behavioral health provider capacity to support shared decision making and overall recovery.**

*UPMC Center for High-Value Health Care*
Number of completed CommonGround Reports by Agency in 2015

<table>
<thead>
<tr>
<th>TCV</th>
<th>NHS</th>
<th>HH</th>
<th>TNCS</th>
<th>FHR</th>
<th>MBH</th>
<th>MBH2</th>
<th>NECS</th>
<th>SCC</th>
<th>Holcomb</th>
<th>ReDCo</th>
<th>BL</th>
<th>BL2</th>
<th>NHS- ACT</th>
<th>NECS2</th>
<th>TOTAL</th>
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<tr>
<td>1,868</td>
<td>373</td>
<td>7</td>
<td>1,018</td>
<td>1,884</td>
<td>1,008</td>
<td>1,375</td>
<td>2,458</td>
<td>1,394</td>
<td>870</td>
<td>1,908</td>
<td>40</td>
<td>2,307</td>
<td>16,510*</td>
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<td>16,332</td>
<td>3,635</td>
<td>392</td>
<td>4,971</td>
<td>111,229</td>
<td>4,585</td>
<td>6,596</td>
<td>14,184</td>
<td>5,914</td>
<td>3,426</td>
<td>7,931</td>
<td>881</td>
<td>3,260</td>
<td>83,336**</td>
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Common Ground Progressive Report Outcomes

Table 2. Endorsement of personal medicine, recovery, and medication concerns at first and most recent report completions.

<table>
<thead>
<tr>
<th>Personal Medicine</th>
<th>First Report</th>
<th>Most Recent Report</th>
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<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>No/none</td>
<td>5584</td>
<td>17.2</td>
</tr>
<tr>
<td>Yes</td>
<td>5584</td>
<td>74.9</td>
</tr>
<tr>
<td>Sometimes</td>
<td>5584</td>
<td>7.9</td>
</tr>
<tr>
<td>Recovery Progress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best ever been</td>
<td>5583</td>
<td>8.5</td>
</tr>
<tr>
<td>Getting better</td>
<td>5583</td>
<td>39.9</td>
</tr>
<tr>
<td>Same</td>
<td>5583</td>
<td>35.7</td>
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<tr>
<td>Getting worse</td>
<td>5583</td>
<td>13.1</td>
</tr>
<tr>
<td>Worst ever been</td>
<td>5583</td>
<td>2.9</td>
</tr>
<tr>
<td>Medication Concerns</td>
<td></td>
<td></td>
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<tr>
<td>Side effects</td>
<td>5584</td>
<td>28.4</td>
</tr>
<tr>
<td>Neg impact on health</td>
<td>5584</td>
<td>27.1</td>
</tr>
<tr>
<td>Meds are helping</td>
<td>5584</td>
<td>55.8</td>
</tr>
</tbody>
</table>

UPMC Center for High-Value Health Care
References


- www.camdenhealth.org
Questions & Discussion
Questions & Discussion

- What specific outcomes are you seeing from engagement-focused programs?
- How do you train staff and build a culture of engagement?
- How do you get a patient engagement program started?
- What are the barriers or challenges to programs or initiatives that are built around consumer engagement?
- How do you amend programs for consumers with complex support needs? How do you adjust consumer engagement strategies for social determinants of health (high poverty, low levels of education, lack adequate housing/nutrition)?
Turning market intelligence into business advantage

*OPEN MINDS* market intelligence and technical assistance helps over 140,000 mental health executives tackle business challenges and maximize organizational profitability.

Chronic Care Management • Disability Supports & Long-Term Care • Mental Health Services
- Addiction Treatment • Social Services • Intellectual & Developmental Disability Supports •
Child & Family Services • Juvenile Justice • Corrections Health Care

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