

The Patient Engagement Prescription

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Written by a volunteer patient advisor, this issue brief provides at 50-foot view of patient engagement as seen through the eyes of various stakeholders including payers, providers, and patients. The benefits and barriers are noted, and the undeniable need for engaged patients is discussed. Many techniques and programs are reviewed including those offered from insurers, clinicians, caretakers, and community members. The overall message builds a case for why authentic patient engagement is the missing ingredient in health care if we truly want better outcomes, better health, and lower costs.

Imagine waiting in a clinic exam room for your provider. The provider enters the room with the health care team. They greet you and pass a printout amongst themselves. Your provider turns and examines you. He quickly turns to the team and discusses his findings in a language that is foreign to you. The team discusses *you* and a care plan “for” you, and then they exit the room.

This scenario describes the traditional health care model through the patient’s view. So many opportunities were missed for the health care team to engage, educate, and partner with the patient. Opportunities to include the patient’s personal preferences in the care plan were left untouched. This issue of the NCMJ builds the case for health care that includes patients and their families in authentic partnerships from the patient’s room to the boardroom; this practice is known as patient and family engagement (PFE).

To come to a consensus about the components necessary for authentic PFE, the North Carolina Institute of Medicine recently convened a diverse group of health care stakeholders: patients, caretakers, insurers, providers, nonprofit organizations, and public health and content experts. The task force used the article “Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies” [1] as a starting point in their work. This article suggests that there are many levels to PFE, and it conceptualizes engagement as taking place on 3 levels. At the patient care level, patients and providers make decisions based on the medical evidence, patients’ preferences, and clinical judgment. In the second level of engagement—organizational design and governance—health care organizations reach out to patients for input to ensure that they are being as responsive as possible to patients’ needs.

Finally, in the policy making level, patients are involved in the decisions that communities and society make about policies, laws, and regulations in public health and health care [1].

The National Academy of Medicine defines PFE as, “a set of behaviors by patients, family members, and health professionals and a set of organizational policies and procedures that foster both the inclusion of patients and family members as active members of the health care team and collaborative partnerships with providers and provider organizations” [2]. In this definition, “family” is anyone the patient deems as family, regardless of biological kinship.

This partnership between providers, patients, and families is crucial to meeting the Institute for Healthcare Improvement’s Triple Aim of improving the health of the population, improving the patient experience of care, and reducing the per-capita cost of health care [3]. With shifts toward value-based care, the importance of patient engagement, experience, and satisfaction are growing as patients seek to play a larger role in their own care. If patients understand their condition, know the symptoms to watch for, know why they are taking medication, and understand how to implement necessary lifestyle changes, then the chances of them getting and staying healthy are significantly improved. PFE deliberately looks for or creates ways to increase patient involvement.

A model of engagement developed by James Conway at the Institute for Healthcare Improvement is organized around the settings in which patient engagement occurs: during the care experience, within the microsystem of the clinic or ward, within the health care organization, or within the larger community [4]. Wherever engagement takes place, emerging evidence shows that patients who are actively involved in their health and care achieve better health outcomes and have lower health costs. Thus, patient engagement and activation are increasingly understood to be factors in achieving the Triple Aim [5]. The challenge is encouraging patients and providers alike to embrace engagement and to work to achieve its full potential.

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Strategies for improving the quality of care in the United States increasingly include a focus on the patient's role in managing his or her health. The widely adopted Chronic Care Model calls for health care system redesign that enables proactive teams of clinicians to interact with "informed, activated patients"—patients who have the motivation, knowledge, skills, and confidence to make effective decisions to manage their health [6]. The significance of patient activation has been recognized in current health care reform efforts.

More attention is also being given to the family in regards to health care reform efforts. Family members are the people who know the patient best and who will provide care and support for the patient outside of the health care setting. They must be included when providers offer training about a patient's care regimen, and the caretaker's health and abilities must be considered when creating care plans. Available support services are also necessary to aid caretakers in their care of family members.

Patients look to health care to set the atmosphere for partnership. In an atmosphere of patient inclusion, signs of patient activation or readiness to participate can be measured. A popular tool for this purpose is the Patient Activation Measure developed by Judith Hibbard, a professor of health policy at the University of Oregon. This measure assesses a patient's level of activation, which allows providers to more appropriately tailor health care interventions [7]. Coupling this patient activation measurement score with other communication techniques, health care providers can meet patients where they are in terms of health literacy and can individualize standard patient education for better outcomes.

Patient engagement is far more than a buzzword. Rather, it is the missing component in 21st-century health care. PFE has garnered extremely useful collaborations both with patients who speak up about their experiences and with patients who serve on committees in organizational design, governance, and policy making. Published data shows improved quality scores, financial savings, and staff morale improvement through the involvement of patients on committees and frontline rounds. Patient engagement is about shared leadership and a shift in culture—a shift that must be a personal commitment.

The following article summaries provide a glimpse of the content of this issue of the NCMJ and spotlight the many branches of a health care system that is truly centered on PFE.

In one commentary in this issue, Maureen Maurer and coauthors dissect the foundational article of the North Carolina Institute of Medicine's task force on PFE. Their commentary focuses on why the tools developed to address PFE are so important [8]. Maurer and coauthors dive deeply into the 8 strategies for change, describing priority areas for action in practice and research that work together in synergy with concrete action steps and resources.

In another commentary, Mary Sue Collier takes the position that true patient engagement is an individual choice and a journey [9]. She compares other industries with health care, emphasizing that all are about customer service as it relates to an organization's beliefs, values, vision, policies, and norms. Several examples are given depicting health care's current state, in which policies and procedures are created "for" patients. As a seasoned clinician, Collier even writes of her personal shortcomings in patient engagement and discusses why she made the individual choice to change. This article discusses 3 key behaviors and poses poignant questions for the health care workforce.

With all the new requirements on providers and practices, it is a challenge to maintain caseloads effectively. Patients must be assisted in making behavior changes and in being an active member of the team. In a sidebar in this issue, Elizabeth Graves and R.W. Watkins describe motivational interviewing, an evidence-based model that aids in behavior change efforts [10]. Although specific techniques for motivational interviewing can easily be learned, trained providers must practice these skills to master them and garnish the best results. Motivational interviewing provides a path back to connectedness with patients—a path that can bring healing to patients, practices, and providers.

To provide readers with a patients' perspective, Melissa Thomason, Margaret Toman, and Matthew Potter share their personal stories about the power of patient engagement [11]. By being willing to speak up, these individuals allow the reader to see health care through the lens of a patient or caregiver. The views are positive and demonstrate how true patient engagement can affect outcomes. The high level of gratitude for their providers is very obvious, and their experiences have led them to be volunteer patient advisors. This commentary demonstrates how authentic patient engagement starts with 3 simple things: dialogue, understanding, and mutual respect between people.

Joan D. Wynn, the lead quality officer for a large health system, discusses in her commentary how her organization partnered with patients in the context of patient-family advisor councils [12]. The harmful events that necessitated the need for better quality practices are discussed, as is the establishment of a corporate office of patient experience. The health system's data shows the positive impact of having a patient on the team. This commentary gives a brief overview of how advisors are chosen and the process to vet them, along with describing some of the actual projects on which advisors have partnered. The key factors in the success for these partnerships are provided, and the article shares some of the resources used.

Blue Cross and Blue Shield of North Carolina has developed a multitude of programs and services to promote better patient engagement, primarily through network configuration, plan design, rewards for participation, and other member incentives. In his sidebar, Brian J. Caveney discusses many of these programs in regards to their respec-

tive stakeholders [13]. Some incentives take only minutes to complete but have a large impact on service and behavior. While incentives alone will not spark patient engagement, hopefully it will increase personal awareness of health care spending and costs.

In another sidebar, Hannah Klaus provides a compelling view of health care through the eyes of a young adult [14]. This sidebar shows that we should not look at young people (10–24 years old) as the uninvolved generation; rather, they are a generation that is working for positive changes in their communities. If young adults are equitably invested in, partnered with, and able to exercise their role as stakeholders in the health care system, they can provide a valuable contribution to the ongoing conversation about health care. Groups like Youth Empowered Solutions (YES!) are providing training and platforms for youth to be heard and to speak about patient engagement to their peers and to health care providers. Youth are taking ownership of their health at a much earlier age because of these types of programs.

Showing that PFE can also work in the outpatient setting, Warren P. Newton and coauthors describe in detail the formation of UNC Family Medicine Clinic's patient advisory council [15]. This article reviews the UNC Family Medicine Clinic's selection and training of patients and the challenges of starting and maintaining a patient advisory council in a primary care practice. The work of the patient advisory council and its impact on the practice is, without a doubt, evidence that the patient's voice makes a positive difference in health care—from daily operations to research and beyond.

Ideals come from research and theory, but the real work is from practice. As Mimi M. Kim and Sharon Elliott-Bynum describe in their commentary, the CAARE program of Durham exemplifies what can happen when theory meets determination [16]. The CAARE program's founders saw a need in their community, met their community members where they were, and made a variety of services accessible, including health care, health literacy, and support. The program partners with physicians, nurses, dentists, farmers, and local businesses to reduce the number of people with major health conditions in their community—all in an atmosphere of respect and dignity. That is patient engagement at its finest.

Engaging patients is not rocket science; if it were, health care could adapt quickly. For true patient-engaging care, medicine must go back to the bedside. In his commentary, Peter R. Lichstein takes a deep dive into the return-to-bedside initiative at Wake Forest Baptist Health [17]. He also relates the decreased mortality, shortened length of stay, improved patient satisfaction, reduced nurse turnover, and improved clinician happiness seen at Emory University. Deliberate and organized techniques for bedside reporting are described, including use of the communication model PEARLS (Partnership, Empathy, Apology, Respect, Legitimization, and Support), structured interdisciplinary bedside rounding, and the choreography of bedside rounds.

Although use of these techniques has shown positive results, bedside rounding is not for all patients in all areas of the hospital, and it does require training.

Finally, Thomas J. Hoerger and colleagues review a Medicaid program that aims to prevent chronic disease through the use of patient incentives [18]. As part of the Patient Protection and Affordable Care Act of 2010, the Centers for Medicare & Medicaid Services awarded grants to 10 states as part of the Medicaid Incentives for the Prevention of Chronic Diseases program. Hoerger and coauthors review in detail what the 10 states did regarding incentives to lower chronic diseases like cancer, diabetes, heart disease, respiratory conditions, and stroke. Although the monetary value of incentives ranged from \$20 to \$1,150 per Medicaid patient, data on whether the current programs actually engaged beneficiaries and led to better health behavior, improved health outcomes, and/or lower Medicaid costs are still unknown. The research period and evaluation of this program will not end until December 2015.

Each of these authors has provided insight from their angle. In some situations, ways to combine efforts for the citizens of North Carolina are obvious. In other ways, we must learn to coordinate our efforts. We have many entities that others could learn from or even duplicate efforts to improve the health of all North Carolinians. This issue brief also unveiled some of the gaps that patients and others see and feel, including caretakers. We all agree that patient engagement must be a part of all health care-related prescriptions. **NCMJ**

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