



RPCC

Regional Primary Care Coalition

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Patient Engagement

A Framework for Improving
Health and Lowering Cost

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About RPCC

The Regional Primary Care Coalition (RPCC) is an active collaboration and learning community of primary care provider coalitions serving the region's low income residents and health philanthropies in Washington, D.C., Northern Virginia, and Suburban Maryland.

We are committed to reducing health disparities and advancing health equity in the region; improving the health status of the region's residents; and fostering the creation of coordinated, patient-centered systems of community-based primary care that make excellent, affordable, linguistically and culturally appropriate health services available to all across the region.

Summary

The Institute for Healthcare Improvement's Triple Aim framework for improving the U.S. health care system—enhancing the patient experience, improving population health and lowering the cost of care—pivots on the patient experience. People may be engaged in their own health care at several levels, from taking ownership of their health and empowering others at the highest levels, to interacting with a less empowering medical model at a more basic level. However, all levels can be a step toward the goal of achieving the highest level of patient experience, in which people are in charge of their health and health care at home and in the community.

The Regional Primary Care Coalition of the greater Washington, DC area has chosen to examine the literature on patient experience and to draw from the clinical experience of the region's safety net clinics to create a model of patient engagement aimed at improving the patient experience for the safety net populations in our region. This is an ambitious task; it is, however, a critical one. According to Catherine Craig and Eva Powell, Institute for Healthcare Improvement Triple Aim faculty, patients and their families are “the single-most underutilized resource in our overburdened, overpriced health care system.” The degree to which patients develop ever-increasing knowledge of health and health care, and take command of their health at home, within the health care system, and in their community, is tantamount to the degree to which we succeed in improving the overall population's health and in lowering costs.

Patients and their families are “the single-most underutilized resource in our overburdened, overpriced health care system.”

– Catherine Craig and Eva Powell,
Institute for Healthcare Improvement Triple Aim faculty

Patients' taking command of their health will particularly aid the management of chronic diseases, which are among the major cost drivers in U.S. health care. Patients' contributions to health system redesign will help create a health care system that better responds to patient needs in the most cost-effective way. Partnering with patients through community resources such as churches, schools, and workplaces—all of which impact health—will also lower costs while improving health. According to Craig and Powell, “By engaging patients and families at multiple levels of organizational performance, we can not only improve their own health care experiences, but also gain valuable insights for actions necessary to improve the health of populations and to extract greater value from our limited health care resources.”

The Dimensions of Patient Engagement

Here, we present dimensions along which both patients and health systems may fall with regard to their level of engagement. At the most inclusive level, people are actively engaged in the health of the community (population health), acquiring and sharing health information with their communities, and are active in civic engagement around a variety of health issues. With the goal of reaching this level in mind, we outline levels at which health systems and people can engage along the way.

A simple step that health systems can take to engage patients is to ask for patient feedback on medical services. The health system can also engage the patient voice in the clinical encounter itself, informing people about their conditions and treatment options and adopting shared decision making models. Health systems then begin to partner with patients to value their voices beyond the clinical encounter, e.g., by offering programs to increase health and health systems literacy and involving patients in advisory committees for quality improvement. With increased literacy and voice, people build the confidence to manage their conditions, better navigate the health care system and better understand the socioeconomic factors affecting health. As people achieve this level of “ownership” of their health, they can become leaders in their communities to improve population health at lower cost.

We understand that patients may engage at different levels. The goal is not for all people to be engaged in the health system at the highest level, but rather, for the health system to be designed and structured to accommodate patients at all levels and empower those who have the desire and ability to engage in population health and lowering cost at the highest level.

The Goal for Engagement

People are community health actors and advocates using their voice to improve population health and health care and to lower costs. They have assumed ownership of their health and their health care and are themselves their primary caregivers. They are further empowered to extend their health knowledge into every aspect of their own lives as well as into their communities, engaging their communities to pursue better health care and better health at lower cost.

Such empowerment entails a deep understanding of and action upon the social determinants of health, the public health framework incorporating social and economic factors in the understanding of the health of people and of communities.

Prior Work

In examining patient experience, two endeavors in the current research on the patient experience are particularly notable: first, the movement toward participatory medicine, and second, the work on patient activation.

The Society for Participatory Medicine proposes “a cooperative model of health care that encourages and expects active involvement by all connected parties...as integral to the full continuum of care. The ‘participatory’ concept may also be applied to fitness, nutrition, mental health, end-of-life care, and all issues broadly related to an individual’s health.”¹

The Society's journal, blog, working groups and committees are thoughtful resources on many aspects of the patient experience. The Society aims "to proactively minimize the effect of the digital divide in the development of participatory medicine in minorities and disenfranchised populations."²

In "Spock, Feminists, and the Fight for Participatory Medicine: A History," Michael L. Millenson calls the inclusion of "patient-centered care"—among the six aims for the health care system by the Institute of Medicine (IOM) in 2001—a turning point toward participatory medicine. The article correctly points out that while the IOM legitimized the focus on the patient, "Legitimization is not the same as implementation."³ The legitimization of sharing power with patients has as yet a long road to travel.

With increased literacy and voice, people build the confidence to manage their conditions, better navigate the health care system and better understand the socioeconomic factors affecting health.

The Patient Activation Measure (PAM) is a scientifically documented measure of how "activated" an individual patient is. Judith H. Hibbard and her colleagues at the University of Oregon maintain that "the participation of activated and informed consumers and patients" is necessary to improve quality and control costs.⁴ They define health activation as follows:

Those who are activated *believe* patients have important roles to play in self-managing care, collaborating with providers and maintaining their health. They *know* how to manage their condition and maintain functioning and prevent health declines; and they have the *skills and behavioral repertoire* to manage their condition, collaborate with their health providers; maintain their health functioning, and access appropriate and high-quality care.⁵

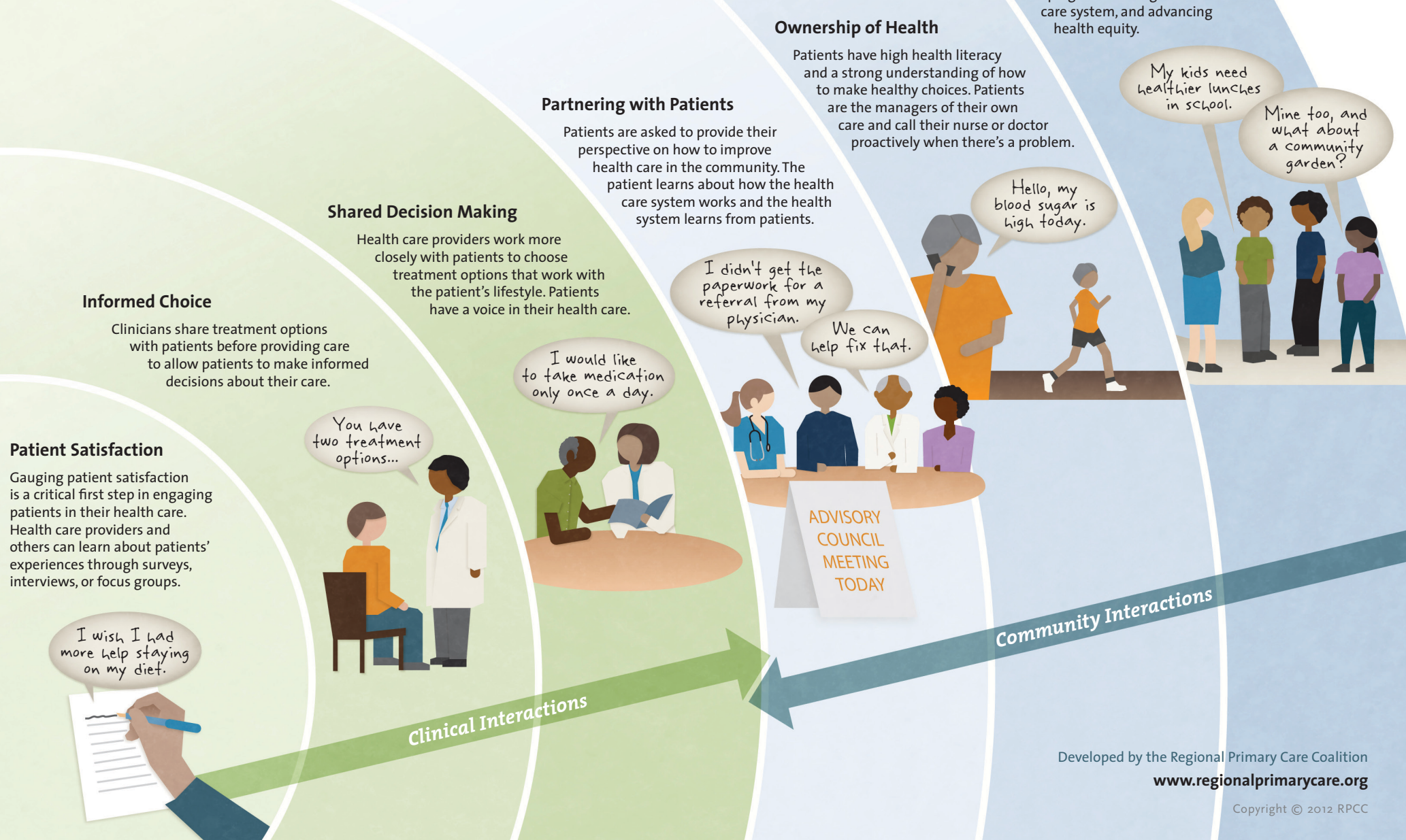
PAM researchers found that activation is "*developmental* in nature: the different elements of knowledge, belief and skill that constitute activation have a hierarchical order."⁶ That order falls into four stages, involving: 1) beliefs about the importance of the patient role; 2) confidence and knowledge necessary to take action; 3) actually taking action; and 4) staying the course even when under stress.⁷ We will refer to those levels to illustrate parts of our schematic of patient engagement.

The levels of patient engagement that contribute to positive patient experiences and foster improved health outcomes are illustrated on the next page. These levels are based on a literature review and the clinical experience of our region's safety net clinics. Reaching the optimal level has broad implications for improving the health of a population and improving the health system with regard to quality and cost.

In addition, some frequently asked questions are found on page 14 and a tool for gauging the levels of engagement that a health system currently provides is included on page 16. A resource guide highlighting innovative patient engagement work across the nation that informed our framework is available at <http://www.regionalprimarycare.org/innovations/documents/PatientExperienceResources-11-8-11.pdf>.

The Dimensions of Patient Engagement

Patient engagement encompasses both clinical interactions with the health care system as well as community interactions with family, friends, and neighbors. Patients may choose to engage at any dimension, but health care systems and communities must enable patients to engage at the most empowering dimensions. Empowered patients can improve the health of communities and lower the cost of care as patients make healthier choices and help their families and communities do the same.



Level 1 *Patient Satisfaction*

Definition

A level where patients' reactions to and views of their experience in accessing and receiving services are sought and considered but where the clinician makes the decisions and the systems for access (appointments, referrals) are set for patients. Patient satisfaction is several steps removed from the highest levels of "patient-centered" care and of the patient engagement in which patients are active participants in their care. Surveys and other opinion-gathering tools should be regarded as a critical step toward more patient involvement, not as an end in themselves.⁸

Characteristics of this Level

A variety of mechanisms are used to obtain patient and family opinions. These mechanisms and the measurements they use are valued within the organization and are regularly refined, improved and maintained.

Clinicians and administrators interpret the results of the surveys and other information gathering techniques and use them to identify areas needing improvement and to help them make improvements.

Benchmarks toward "Patient Satisfaction"

- ☐ Systematic mechanisms are used to regularly collect patient opinions. The mechanisms are linguistically appropriate and make it possible for patients, regardless of literacy level, to participate. Results are analyzed and used to make system improvements.
- ☐ The responsibility for engaging patients and obtaining information related to "satisfaction" is clearly defined within the health care organization.
- ☐ The questions used to obtain information on "patient satisfaction" are designed to obtain a broad array of information and are deemed appropriate by stakeholders who are working on improving the patient experience.
- ☐ The instruments and processes used to gather information are periodically reviewed to assess the adequacy and utility of the information collected as well as to identify challenges in getting patients to respond and to assess the organization's capacity to administer the survey. Efforts are made to address the issues identified, and other techniques for getting a fuller picture of the patient experience (e.g., different surveys, individual interviews, focus groups, community stakeholder meetings) are adopted where needed and feasible.
- ☐ A representative group of stakeholders, including patients, are involved in interpreting the data and developing recommendations.



Level 2 *Informed Choice*

Definition

A level where the clinician explains things to patients so that they are informed but the clinician makes the decision on the appropriate treatment. At this level, the “pre-set GPS”⁹ of the primary, specialty, sub-specialty and hospital care systems regarding appropriate treatment results in a decision regarding the patient.

Characteristics of this Level

The clinician decides on the appropriate treatment and then gives patients the information they need to make an educated decision to accept or reject the treatment.

There are materials available in languages and at appropriate literacy levels that give patients sufficient information to help them make an informed choice.

Clinicians give little attention and time to eliciting all of the concerns of patients, their goals, values and agenda for seeking care.¹⁰

Benchmarks toward “Informed Choice”

- ☐ Stakeholders examine the various ways that providers explain health care choices to patients, attempting to determine the scope of information presented, the methods used to inform patients, the time taken to do so and the level of clinician(s) who presents the information.
- ☐ Stakeholders are looking at the “pre-set GPS” of the medical decision making system among their providers to understand where the patient does or does not fit into the GPS.
- ☐ Stakeholders try to determine whether any attempts are made to solicit the patient’s goals, values or agenda.



Level 3 *Shared Decision Making*

Definition

In shared decision making, patients have a voice in everything that happens to them in the clinical encounter(s).¹¹ It is a major step toward people directing their health care at higher levels of engagement. Above all, it encourages “beliefs about the importance of the patient role,” which constitutes the first stage of the Patient Activation Measure.¹²

Characteristics of this Level

Stakeholders, including health care providers, put a priority on including the patient in every step of the clinical encounter. They also commit to increasing the level of patients’ health literacy.

Providers understand the need and are open about learning how to better communicate with patients.

Benchmarks toward “Shared Decision Making”

- ☐ There is on-going education and training of providers in communication skills directed to advancing shared decision making and to building patient literacy implicitly even when communication focuses on a patient’s particular condition(s).
- ☐ Up-to-date and linguistically and culturally appropriate resources and decision aids are being used to foster shared decision making. The resources and aids are in languages and at literacy levels appropriate to the patient population. The tools provide for and allow time for patients to ask questions. Stakeholders have had a role in their development.



Level 4 *Partnering with Patients*

Definition

When partnering with patients, health systems seek out patient voices to be heard at the health systems level. At the Partnering with Patients level, actors and structures—such as governmental advocates and navigators, consumer advocates, health plans, health care clinicians, purchasers and the media—enable the empowerment of patients. For instance, within the context of recovery-oriented mental health services, certified peer specialists encourage consumers to participate more in their treatment goals and services.¹³ This level could also include structures like Community Health Advisory Committees.¹⁴ In addition, the Society for Participatory Medicine regards closing the gap on the digital divide as a key part of empowering patients.

Partnering with Patients corresponds to the Patient Activation Measure's second stage in which patients have “the confidence and knowledge necessary to take action, including medications and lifestyle changes, confidence in talking to health care providers and knowing when to seek help, and (at slightly higher levels of activation) confidence in following through on recommendations, knowing the nature and causes of the health condition and different medical treatment options.”¹⁵

Characteristics of this Level

All stakeholders—providers and patients—recognize the critical importance of the social determinants of health in the overall health of the patient. They also commit to addressing the factors that affect health, such as access to transportation and healthy foods, as a critical components of each patient's journey toward better health.

There is a highly coordinated structure in which patients can function and through which they can grow in their ability to understand their health choices and improve their health. Patients are given tools that enable them to be effective caregivers, e.g., a list of questions to ask about their condition and treatment options.¹⁶

Health care and social services systems work with the patient to improve access not only to health care but also to social services that address the social determinants of health. The guiding principle is to help patients deal effectively with their problems and to create consumer engagement according to the principle, “If they build it, they will come.”¹⁷

Efforts are being made to improve access to benefits that, while tangential to clinical health care, are critical to improving health. The Affordable Care Act emphasizes the vertical and horizontal integration of benefits. Food assistance (SNAP), children's health (CHIPRA) and Medicaid are particularly aligned, but assistance with fuel and energy, housing, child care, and Temporary Assistance for Needy Families and the Earned Income Tax Credit is part of a more comprehensive approach.¹⁸

Benchmarks toward “Partnering with Patients”

- ☐ Dedication to increasing health literacy can be documented and results demonstrated. Efforts to increase health literacy are actively taking place throughout all patient encounters; health care providers take time to proactively inform and teach patients about their health by explaining their conditions and choices very clearly to them.
- ☐ Structural improvements are in place to integrate social determinants, social services and medical care: Such improvements might include using patient advocates, navigators, community health workers, outreach workers and benefits counselors to help link patients to needed services and supports. They might also include changing appointment types or times, transportation, parking availability or childcare.
- ☐ Community involvement is evident: Community health advisory committees, community needs assessments, focus groups and community meetings are critical in truly involving the community.



Level 5 *Patients' Ownership of Their Health*

Definition

At this level, patients are their own primary caregivers and are the most important part of the health delivery team with regard to the entire spectrum of needs and care.¹⁹ Kaiser Permanente asserts that with regard to chronic conditions, “Patients should not be seen as ‘consumers’ of health care, but as the primary ‘providers’ of health care.”²⁰

At this utmost level of activation on the Patient Activation Measure,²¹ patients “are confident they can maintain lifestyle changes when under stress, that they can handle problems (rather than simply symptoms) on their own at home and that they can keep their health problems from interfering with their life.”²² According to Sandy Graham, Managing Editor of the Colorado Health Foundation’s *Health Elevations* journal, “The nation’s broken health system can only be fixed if people step forward and take charge of their bodies and their treatment... In this new approach, health care professionals empower individuals to take an active role in their own health by providing the information and resources they need to change behavior that impacts their health.”²³

Characteristics of this Level

Patients have a high level of medical and health literacy.²⁴ Developing high literacy levels must be a priority at every encounter of care. Health literacy cannot be overemphasized. Just as CEOs have limited knowledge of certain aspects of the businesses they run and must rely on staff and experts to provide critical information, advice, and guidance, patients are CEOs of their own health care. As fully empowered users of health care, patients are able to use health care providers effectively much like CEOs use consultants: “The patient or her caregiver ultimately has the autonomy for decision making. The provider should be a trusted consultant who can minimize bias and provide recommendations based on expertise and experience. To be clear, providers must make these recommendations cognizant of their duty to ‘do no harm’ and therefore, cannot perform a harmful surgery or risky test solely because of a patient request.”²⁵

Another example of concerns antibiotic use. Limited patient knowledge, direct-to-consumer advertising and pressure on physicians to prescribe increases the likelihood that patients will use antibiotics when they don’t need them, which ultimately contributes to antibiotic resistance in the population. We cannot assume that patients who own their health would choose more antibiotics; rather, fully informed and empowered patients would likely choose to use antibiotics only when truly needed. A good consultant may and should say “No” to patients requesting medications when they aren’t truly needed, informing the patients about why.

Patients’ voices are informed and heeded and they direct their own behavior. They know how to relate to various elements of the health care and social services system to get what they need. Here, social services “consultants” aid people in accessing and maximizing social services and in understanding the link between their social circumstances and their health (the “social determinants of health”). Information technology can play a critical role in this level, particularly the many efforts underway to integrate benefits and make them more accessible to people.

Characteristics (continued)

Patients in the health care system are informed decision makers about their choices, including understanding cost-benefit aspects of clinical care. They can more easily become engaged in civic decisions about how to pay for health care and allocate health care resources.²⁶ Patrick Quinlan, CEO of Ochsner Health System in New Orleans, emphasizes that patients should not be shielded from the consequences of their choices, if they make lifestyle choices that affect their health and health care costs.²⁷ Similarly, the two highest stages of activation in the Patient Activation Measure are the third stage that “involves actually taking action, including maintaining lifestyle changes, knowing how to prevent further problems, and handling symptoms on one’s own,” and the fourth stage that “involves actually staying the course even when under stress.”²⁸ As Humana President and CEO Mike McCallister emphasizes, it is critical to engage people to live well now and to manage their own health.²⁹

Benchmarks toward “Patient Ownership of Their Health”

- ☐ The level of health literacy that has been achieved in lower levels of engagement extends into a deeper knowledge of a patient’s own conditions, a broader knowledge of health choices available to them and the health of the community (population health) and how to make best use of the expertise of the health system.
- ☐ Patients demonstrate substantial knowledge of the health system, of how social determinants affect health, of the importance of civic participation to improve the quality of health and social services and of how to improve value in the system (that is, better outcomes for lower costs).



Level 6 *People Engaged in Population Health*

Definition

At this level, patients and their social networks are their own primary caregivers and are the most important part of the health delivery team with regard to the entire spectrum of needs and care.³⁰ Patients themselves act as community health workers and advocates, helping each other navigate the health care system, seeking the best prevention and treatment options together and advocating that the medical system—as well as transportation, housing, the built environment, and education—develop conditions that improve population health.

Characteristics of this Level

People have moved from being followers to being leaders. The concept of “People Centered Care” is extended into the community.³¹ In British Columbia’s Patient Voices Network, patients “participate in decision making so that BC’s health care reflects the needs and priorities of those it serves—the patients.”³² At a systemic level, the Network envisions that “patients, families, communities and/or strategic partners are engaged in strategic planning or policy making activities, including setting priorities, informing resource allocation decisions and playing a role in governance.”³³

People use experience from their daily lives beyond their clinical encounters to build further knowledge and to share it with their families and communities. In British Columbia’s Patient Voices Network, patients “connect with each other face-to-face, by phone and online to share experiences and learnings.”³⁴ As leaders, patients engage their fellow community members in health. In the Patient Voices Network, peer coaches “support and motivate [peers] to a healthier future” by supporting their success in active living, healthy eating, managing a healthy weight, or stopping / reducing smoking.³⁵ Patients do the work—often done by community health workers—of educating community members, helping them navigate the health care system and demanding that the health care system provide better care for communities.

The health system, broadly defined, then, becomes a catalyst for a stronger social contract that includes individual, societal and fiscal responsibility. On this level, the person is acting largely outside of, though in tandem with, the health system. The community learns to interact productively with the health system and the health system learns to interact with the community.

Benchmarks toward “People Engaged in Population Health”

- ☐ People seek and use knowledge of the health system and of how social determinants affect health in civic engagement within their communities and states, to improve the quality of health and social services and to improve value in the system (that is, better outcomes for lower costs).
- ☐ Community-based structures—such as advocacy organizations and peer social networks through which patients can find voice—facilitate people’s participation in improving the health and social services systems. Patients grow from followers to leaders in their communities.



Looking Ahead

The health care system is now progressing through these stages toward the ultimate goal: People Engaged in Population Health. The challenge lies in the implementation: getting patients, communities and providers to work together to develop the dimensions that help bring them to ever-higher levels of the patient experience.

Our diagram attempts to visualize the inter-reliant relationships between the patient experience, improving population health and lowering costs, the three legs of the Institute for Healthcare Improvement's Triple Aim framework. Only by approaching the implementation of the Triple Aim first through the patient experience will we bring about productive involvement of all people and achieve lasting improvements in quality at lower costs.

Frequently Asked Questions

Is it necessary to positively engage patients?

Yes, it is absolutely necessary.

Dr. Mauvareen Beverley, former Associate Executive Director, Care Management, Queens Health Network, who passionately believes in the elimination of negative language in describing patients, shared a story about a patient who came to the Emergency Room every month for a chest x-ray for at least 4-6 months and was referred to as a “frequent flier”. Here is the patient’s story.

The patient went to his private doctor, and was told he had a virus, which turned into pneumonia, and he was admitted to the hospital and had tubes placed in his chest. Post discharge, he presented to the ED the same time every month for a chest x-ray. In the ED, he was referred to as a “frequent flier” and he always requested a chest x-ray. The Care Management Program at QHN required care managers to ask the question “why?” The patient reiterated the story above and explained that the reason he comes to the ED is because of his fears and he never wanted to have tubes in his chest ever again. When asked why he comes the same time every month, he says he’s off from work at that particular time on that day. The hospital then contacted the man’s primary care physician and notified him of the patient’s fears and request for sequential chest x-rays. Since contacting his primary care doctor, the patient had not been back in the ED for repeat chest x-ray, to our knowledge.

There are many patients like this man who want to be proactive about managing their health. If we can empower such patients to manage their health in the appropriate way, it will take costs out of the system and improve population health.

What does it mean for doctors if patients “own” their own health?

We think that doctors enter the medical profession with a sincere desire to make their patients’ health better. The Patient Engagement framework requires a paradigm shift in which providers recognize that empowering patients to manage their care better in their daily lives will help patients make their health better. At the 2011 Agency for Healthcare Research and Quality Conference, Dr. Samer Assaf, a provider at the Sharp Rees-Stealy Medical Group in California, said that when he started practicing, he would give the same scripted lecture to his patients depending on what disease they had, regardless of their level of activation, motivation, support or health literacy. For instance, the patient who smoked would be handed a smoking cessation pamphlet and given a scripted lecture. Then 3 to 6 months later, the same patient would come in and there would be no change, and Dr. Assaf would still hand out the same pamphlet with the same recommendations to quit smoking.

He was going over the same routine expecting different results. Initially, he found this both unproductive and frustrating, but it soon became routine and it was easy for him to blame the patient for the lack of improvement. Then Dr. Assaf started working with a shared decision making model. It was a complete shift for him as a provider to ask patients questions about what they could realistically do regarding their health and provide them with support to help them manage their own conditions and health. It made his work much more fulfilling because he was actually helping his patients get better. That is what we hope will happen when providers embrace this model.

What kind of doctors would engage this framework? What changes in the type of doctors trained or how medical education is conducted do you envision?

Providers should not think, “What can *I* do to make this patient better?” but rather, “What does this patient *need* in order to get better?” An eye doctor last year prescribed new contact lenses for his patient. At the end of the visit, the patient told him that no one had actually ever shown her how to clean her lenses properly. He very honestly and politely said that he could only answer questions about what he knew: the medical aspect of the eye, and not how to clean lenses. He spoke to what he thought were his role and his limitations, and as a result, left the patient vulnerable to future eye infections which could require additional future care and add to her health care costs.

Instead, doctors should be trained to ask themselves, “What does the patient actually need for better health? She needs to know how to clean her lenses properly so that she doesn’t come back with an eye infection. I’m going to train myself or find a nurse who can teach her that.” Providers need to think beyond the clinical encounter to other factors that impact health, asking themselves, “What is the patient doing in their home that is causing the symptoms I see?” They may then realize, “I don’t know anything about this patient’s lifestyle – so maybe I’ll ask the patient!” They also have to engage the care team—which includes the patient—to provide a coaching as well as a medical role.

So many patients are at a very low level of medical literacy now. How can we catch people up? Enrollment in the ACA is going to require a certain level of literacy about access and choices of plans, and we already know that many, many patients don’t have the level that will enable them to enroll correctly. What are your ideas for tackling these problems?

Patients cannot get to a high level of literacy by themselves, which is why we say that the health system’s role is to support and empower them. Jeanie Schmidt Free Clinic conducts interdisciplinary group medical visits to educate patients about diabetes and hypertension, thereby serving a low-income population through a very high level of engagement. So maybe there are ways that we can help out patients who have low literacy levels, by giving them oral and written instructions in a group setting, to reduce costs. This group model also fosters peer education between participants who increase their own competency as they help one another. Otherwise, the physician, physician assistant, nurse practitioner or nurse needs to take the time to explain the particular medical terms being used in that encounter—again and again—until the patient becomes conversant with the terms. It is time and labor intensive, but it pays off in the long term—for the provider-patient relationship and for the patient’s health.

Pulse Tool

Patient and Family Roles

Tool for taking your program's 'Pulse'

Interventions	Tried? Yes/No	Implications: How did we use the information we gained?	Patient Satisfaction	Informed Choice	Shared Decision Making	Partnering with Patients	Patient Ownership of Their Health	People Engaged in Population Health
Survey (formal and informal approaches)			✓					
Access to meaningful information				✓	✓			
Patient-specific education				✓	✓			
Provider-Patient informal conversation					✓			
Hold focus groups with patients representing targeted populations with unmet needs						✓		
Involve patients in QI efforts						✓		
Patient role in organizational decision-making (e.g. Patient Advisory Council)						✓	✓	
Staff development						✓	✓	
Self-management tools				✓	✓	✓	✓	✓
Meaningful opportunities for patient and family voice in QI activities and operational decision-making						✓		✓
Partnering with existing community resources						✓		✓

Collaborative product of Regional Primary Care Coalition, National Partnership for Women and Families, and Community Solutions
Developed for Institute for Healthcare Improvement Triple Aim Teams

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Endnotes

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About Regional Primary Care Coalition

The Regional Primary Care Coalition (RPCC) is an active collaboration and a learning community of primary care safety net provider coalitions and health philanthropies committed to advancing health equity and improving the health of low-income residents in Washington, DC, Suburban Maryland and Northern Virginia. Its mission is to encourage innovation and strengthen coordinated, community-based systems of comprehensive, high-quality, patient-centered care across all jurisdictions in the region. It is a place where groups cross geographic borders to learn, try out new ideas and share knowledge about what works and what doesn't for ensuring that area low-income residents get high-quality primary health care.

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