From Passive Patient to Active Participant

How to Enhance CV Patient Engagement

Excerpt from the 2013-2014 National Meeting Series

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Road Map

1. Building the Business Case for Patient-Centered Care

2. Imperatives for Engaging Patients Across the Continuum—Enhancing Patient Involvement

3. Coda
Key Forces Driving Urgency

A Recap from Part One of the Series

1) Policies Demanding a Patient Focus
   - ACA\(^1\) mandates a patient focus
   - ACCF\(^2\) creates call-to-action for CV providers

2) Greater Transparency
   - Increased attention to patient centeredness in literature
   - Websites, apps rating patient satisfaction and influencing consumer decision-making

3) Increasingly Tied to Payment
   - HCAHPS\(^3\) score included in value-based purchasing
   - Hospitals paid for how well they perform

4) Accountability for Long-term Management
   - Risk-based contracts and chronic conditions require care over extended periods
   - Must retain patients over time

5) Growing Competition for Patients
   - Patients becoming informed “shoppers” with increase in high-deductible health plans
   - Demanding convenient, accessible care

6) Impact on Cost, Utilization, and Quality
   - Rich body of literature suggests an engaged patient results in improved quality
   - Patient involvement also reduces utilization and cost

Source: Cardiovascular Roundtable research and analysis.

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1) Affordable Care Act.
2) American College of Cardiology Foundation.
3) Hospital Consumer Assessment of Healthcare Providers and Systems.
Rising to the Top of the Agenda

Surpassing Quality, Reimbursement Concerns

Organization’s Top Three Priorities for Next Three Years\(^1\)
n=823

<table>
<thead>
<tr>
<th>Priority</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Patient Experience</td>
<td>54%</td>
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<tr>
<td>Clinical Quality</td>
<td>48%</td>
</tr>
<tr>
<td>Cost Reduction, Process Improvement</td>
<td>45%</td>
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<tr>
<td>Access to Capital</td>
<td>7%</td>
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<tr>
<td>Care Continuum</td>
<td>7%</td>
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<tr>
<td>Care Models (Population Health, Medical Homes)</td>
<td>27%</td>
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<tr>
<td>Physician-Hospital Alignment</td>
<td>27%</td>
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<tr>
<td>Information Technology (Clinical)</td>
<td>26%</td>
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<tr>
<td>Strategic Partnerships</td>
<td>25%</td>
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<tr>
<td>Reimbursement Models, Shared Risk</td>
<td>21%</td>
</tr>
<tr>
<td>Information Technology (Business)</td>
<td>8%</td>
</tr>
<tr>
<td>Information Technology (Clinical)</td>
<td>26%</td>
</tr>
<tr>
<td>Clinical Quality</td>
<td>48%</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>54%</td>
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</table>

\(^1\) As rated by senior leaders, clinical leaders, operational leaders, finance leaders, marketing leaders, and information leaders.

More than Patient Satisfaction Alone

“Patient activation is defined as understanding one’s own role in the care process and having the knowledge, skills, willingness, and confidence to take on that role, and manage his/her own health and care. We use patient engagement to denote a broader concept, including patient activation, the interventions designed to increase it, and the patient behavior that results from it (e.g., obtaining preventative care or exercising more regularly).”

Judith Hibbard

“The Institute of Medicine (IOM) considers care to be patient centered if it is respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions. The IOM further separates patient-centered care into 8 dimensions, including respect for patient preferences, information, medication communication, coordination of care, emotional support, physical comfort, involvement of the family, continuity and transition, and access to care.”

Institute of Medicine

“Eight dimensions of patient-centered care include: patient preferences, emotional support, physical comfort, education and information, continuity and transition, coordination of care, access to care, family and friends.”

NRC Picker

Easier Said than Done

Obstacles to Achieving Patient-Centered Care

**Patient-Related**
- Health illiteracy, cognitive issues
- Not activated in own care, feel no responsibility
- Non-compliance
- Not willing to be inconvenienced (distance, wait times)
- Cost of adherence

**Physician-Related**
- Feel like they do not have control
- Do not buy-in
- Not top of mind, not implemented into daily practice
- Lack time
- Perceive authority is challenged

**Hospital-Related**

Percentage of Respondents Indicating Stumbling Block to Adopting Patient Experience Strategy

- Difficulty Changing Culture: 49%
- Higher Priorities: 20%
- Lack Funding, Budget: 11%
- Lack of Leadership Commitment: 8%
- Other: 4%
- None: 7%

Source: “Patient Experience: Beyond HCAHPS,” HealthLeaders, August 2013; Cardiovascular Roundtable research and analysis.
### Part I: Forming the Foundation

<table>
<thead>
<tr>
<th>I</th>
<th>II</th>
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<tbody>
<tr>
<td>Hardwiring a Patient-Centered Culture</td>
<td>Coordinating Patient Services</td>
</tr>
<tr>
<td>1. Designate a CV Patient Experience Champion</td>
<td>5. Develop Patient-Centered Scheduling</td>
</tr>
<tr>
<td>2. Instill Institution-wide Accountability</td>
<td>6. Reorganize Services Around Patient Needs</td>
</tr>
<tr>
<td>3. Gather Patient and Family Perspectives</td>
<td>7. Evolve Care Coordinator Role</td>
</tr>
<tr>
<td>4. Proactively Address Patient Concerns</td>
<td>8. Support Team-Based Care</td>
</tr>
</tbody>
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### Part II: Enhancing Patient Involvement

<table>
<thead>
<tr>
<th>III</th>
<th>IV</th>
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</thead>
<tbody>
<tr>
<td>Encouraging Patient Activation</td>
<td>Ensuring Compliance and Loyalty</td>
</tr>
<tr>
<td>Special Report: Engaging Patients in Shared Decision-Making</td>
<td></td>
</tr>
<tr>
<td>9. Develop Patient Compacts</td>
<td>Promoting Adherence</td>
</tr>
<tr>
<td>10. Customize Care to Level of Activation</td>
<td>12. Hardwire Follow-Up Appointments</td>
</tr>
<tr>
<td>15. Optimize Patient Portals</td>
<td>Keeping Patients in Network</td>
</tr>
</tbody>
</table>

Source: Cardiovascular Roundtable research and analysis.
Road Map

1. Building the Business Case for Patient-Centered Care

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Encouraging Patient Activation

Patient Activation Driving Higher-Value Care

Associated with Self-Management, Satisfaction, Cost-Reduction

**Association of Patient Activation with Outcome Measures**

*Percent of Patients by Activation Level*

n=4,108, p<0.0001

<table>
<thead>
<tr>
<th>Utilization of Self-Management Services</th>
<th>High Patient Satisfaction with Care</th>
<th>Quality of Life Rated &quot;Good/Very Good&quot;</th>
<th>Medication Adherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 (Low Activation) 49%</td>
<td>Level 4 (High Activation) 61%</td>
<td>Level 1 (Low Activation) 23%</td>
<td>Level 4 (High Activation) 69%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1 (Low Activation) 38%</td>
<td>Level 4 (High Activation) 78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level 1 (Low Activation) 86%</td>
<td>Level 4 (High Activation) 94%</td>
</tr>
</tbody>
</table>

**Patient Costs by Activation Level**

*Average Billed Costs By Condition, All Patients, 2010*

n=12,175, p<0.01

- Hypertension: $7,687 vs $6,750

n=10,515, p<0.01

- Hyperlipidemia: $6,089 vs $5,454

n=33,163, p<0.01

- All Patients: $4,679 vs $4,320

Shared Decision Making in the Spotlight

A Growing Mandate for Patient-Provider Collaboration in Care

Recent Initiatives Driving Focus on Shared-Decision Making

Federal Policies
- SDM\(^1\) a quality measure for MSSP
- PPACA directs HHS to develop Program to Facilitate Shared Decision Making
- SDM a criterion for NCQA patient-centered medical home, specialty practice certification

Private Payers
- Some insurance companies including SDM in evaluating value of hospitals, demonstrations
- Example: Anthem Blue Cross evaluating patient involvement, SDM as criteria for participation in patient-centered care pilots, high-value designations

State Legislation
- States beginning to promote SDM through new laws, incorporation into state standards
- Example: Washington, Vermont, Maine have each passed laws to promote SDM demonstrations

Nationwide SDM Pilots
- Significant investment in demonstrations of SDM in practice
- Example: CMMI issued $26 M innovation grant to 15-member collaborative (including Dartmouth-Hitchcock, Mayo Clinic) for SDM pilot in June 2012


1) Shared decision making.
A Growing Case for Shared Decision Making

Recent Research Demonstrating the Ability to Improve Value of Care

Representative Evidence of the Impact of SDM

More Appropriate Utilization
- 2011 Cochrane Collaborative review of 11 trials
- Evaluated impact of patient decision aids on utilization

Lower Costs
- 2013 RCT\(^1\) of 60K patients with preference-sensitive conditions
- Compared usual care vs. health coach-led SDM model

Improved Patient Experience
- 2012 RCT of 150 PCI patients eligible for both femoral, radial access
- Evaluated impact of patient decision aid of vascular access site vs. usual care
- Aid significantly reduced decisional conflict; improved value congruence, health knowledge

20% Reduction in use of major elective invasive surgery when decision aid used

5.3% Lower 12-month overall medical costs in SDM cohort vs. usual care

8.7% Lower PMPM medical costs for CV patients in SDM cohort


\(^1\) Randomized controlled trial.
A Significant Opportunity to Advance CV Care

CV Services Particularly Well-Suited for Shared Decision Making

ACC Outlines Characteristics of CV Disease Increasing Value of SDM

- Plethora of evidence-based guidelines, AUC
- Availability of validated risk models to inform patients of likely outcomes
- Prevalence of preference-sensitive conditions with multiple appropriate care options
- Chronic conditions with long-term care needs, greater opportunity for patient input on goals, preferences

2012 Ischemic Heart Disease Guidelines Clearly Emphasize Patient Involvement

Vital Importance of Involvement by an Informed Patient: Recommendation Class I

“Choices about diagnostic and therapeutic options should be made through a process of shared decision making involving the patient and provider, with the provider explaining information about risks, benefits, and costs to the patient.”

Still a Long Way to Go

Lack of Patient Involvement Resulting in Patient-Provider Disconnect

**PCI Patients Largely Uninformed**

- **10%** Elective PCI patients who felt they were given alternative options to seriously consider
- **16%** Elective PCI patients who said they were asked about their treatment preferences

### Anticipated Benefits of PCI in Patients Compared to Their Cardiologists

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Performing Physician</th>
<th>Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Mortality</td>
<td>76%</td>
<td>15%</td>
</tr>
<tr>
<td>Prevent MI</td>
<td>85%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Percent of Cases, n=53

**Key Barriers to Shared Decision Making**

- Workflow implications, lack of time
- Lack of incentive under FFS
- Insufficient clinician training, tools
- Perceived as a challenge to physician authority
- Patient, family disinterest

A Library of CV Resources to Support SDM

New Guidelines, Tools Help Providers Engage Patients in Decisions

2012 AHA Statement a Roadmap for Shared Decision Making in Advanced HF

Examples of Guidance Included

- Outline of major decisions patients face, opportunities for SDM
- Scripting to enhance discussions
- Suggested agenda for a SDM-based patient visit

CV Shared Decision Making Compendium

Please see the Appendix for additional tools, resources, and patient decision aids to support shared decision making.

Advancing Patient-Centered Care Through SDM

Mayo’s Comprehensive Approach to Clinician-Patient Collaboration

**Key Goals of Mayo’s Shared Decision Making National Resource Center**

- **Develop, Implement Patient Decision Aids**
  - Design tools to guide SDM at the point of care for chronic, CV patients
  - Refined with feedback from physician, patient advisory councils

- **Evaluate Aids in Clinical Trials**
  - All aids tested in controlled trials both at Mayo, other practices, to ensure efficacy
  - Published results demonstrate benefits of SDM, support adoption

- **Promote Adoption of SDM**
  - Host national, international SDM symposia
  - Educate clinicians within, outside Mayo in patient communication techniques
  - Make all SDM tools freely available to other institutions

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"Our decision aids improve the patient’s ability to participate in a conversation, and the physician’s ability to extract information from this discussion... combining their expertise and evidence with patient preferences so they can arrive at a decision together."

*Victor Montori, MD*

*Mayo Clinic Shared Decision Making National Resource Center*

Source: Shared Decision Making National Resource Center, available at: [http://shareddecisions.mayoclinic.org](http://shareddecisions.mayoclinic.org); Mayo Clinic, Rochester, MN; Cardiovascular Roundtable interviews and analysis.
Components of a Best Practice Decision Aid

- **Personalized risk evaluation based on patient profile**
- **Physician has choice of risk model (e.g., Framingham score)**
- **Graphical representation simple to interpret, regardless of health literacy**
- **Notes section can be copied into patient record**
- **Easy to share with patient, family, PCP**
- **Clearly outlines pros, cons of selected intervention**

Note: The complete version of this and other Mayo patient decision aids can be accessed at the Shared Decision Making National Resource Center website: [http://shareddecisions.mayoclinic.org](http://shareddecisions.mayoclinic.org).
Strategies Guiding Clinician Use

Decision Aids Designed to Reduce Need for Intensive Training

Videos Demonstrate Decision Aids in Action

- Recorded clinicians using decision aids with patients as an example of workflow, scripting
- Share videos at CV department meetings during initial rollout, discuss clinical trial results demonstrating benefits of use
- Available on Mayo website for on-demand access

Storyboards Provide Ongoing Guidance

- Outlines suggested workflow
- Distributed to physician offices
- Tailored to specific decision aid

60% Average degree of fidelity\(^1\) to decision aids in clinical trials


\(^1\) I.e., the percentage of discussion points decision aid developers intend a clinician to address when using the tool with a patient that are covered in real-world use.
Hardwiring SDM into Standard Workflow

Embedding Decision Aids into Clinical Pathways to Support Use

1. Clinician Accesses Decision Aid in EMR
   - Hyperlink to decision aid embedded into appropriate care pathways

2. Tool Auto-Populates Patient Risk Data
   - Uploads data from patient record to calculate risk, incorporates into personalized decision aid

3. Clinician Reviews Aid with Patient
   - Aid guides clinician in discussing treatment options, risks, patient preferences

4. Patient Receives Copy of Personalized Aid
   - ‘Share’ option in tool prints, emails copy of aid to patient to share with family, PCP

5. Clinician Documents SDM
   - Pre-populated ‘notes’ section can be easily copied into patient record, tracks use of SDM

Clinical Trials Demonstrate Clear Benefits of SDM

Chest Pain Choice Illustrative of Mayo’s Decision Aid in Practice

Results of Chest Pain Choice Trial

<table>
<thead>
<tr>
<th>Increased Patient Knowledge</th>
<th>Greater Patient Satisfaction in Decision-Making Process</th>
<th>More Appropriate Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Questions Correctly Answered on Post-Visit Survey</td>
<td>Percent Answering “Strongly Agree” on Satisfaction Survey</td>
<td>Percent of Patients Admitted to Observation Unit for Stress Testing</td>
</tr>
<tr>
<td><strong>Standard Care</strong></td>
<td><strong>Decision Aid</strong></td>
<td><strong>Standard Care</strong></td>
</tr>
<tr>
<td>3.0</td>
<td>3.6</td>
<td>40%</td>
</tr>
</tbody>
</table>

## Additional Strategies for Shared Decision Making

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Example Institution</th>
</tr>
</thead>
</table>
| **Patient Care Journal**        | • All procedural candidates given a condition-specific (e.g., CABG, EP, PCI) care journal  
• Prompts patients to ask specific questions to physician about their health, procedural options, and transcribe answers; carry journal throughout inpatient stay to note ongoing care goals, instructions  
• Ensures patients are truly understanding what is happening in the hospital, as well as all physician instructions, post-discharge needs | St. Vincent Heart Center of Indiana      |
| **Online Patient Education Modules** | • Hospital partners with patient education vendors (e.g., IndiGo, EMMI Solutions, Health Dialogue) to provide patients access to online shared decision making videos, decision aids  
• Patient-friendly tools review options in plain language, help patients evaluate their values, lifestyle considerations that would impact decision  
• Patient feels more empowered and confident in choosing options | Intermountain Healthcare                |
| **Pre-Appointment Decision Aids** | • Patients given access to various decision aids at time of scheduling, prior to initial visit; given opportunity to review at their convenience  
• Enables more robust, informed discussions at time of appointment  
• Increased decision-aid orders tenfold | Massachusetts General                   |
| **Decision Aid Physician Dashboard** | • Physicians receive quarterly reports showing his/her use of decision aids comparing with other physicians in system  
• Increases awareness, encourages regular use of decision aids | Massachusetts General                   |

Source: Christiansen B, et al., *Daily Herald*, March 18, 2013; Butcher L, *Hospitals and Health Networks*, May 2013, 26-31; St. Vincent Heart Center of Indiana, Indianapolis, IN; Cardiovascular Roundtable interviews and analysis.
### Additional Strategies for Shared Decision Making (Cont.)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Example Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDM Quality Measure Rollout</td>
<td>• Two-quarter rollout of SDM quality improvement metrics</td>
<td>Massachusetts General</td>
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<tr>
<td></td>
<td>• In first quarter, each physician had to view one of the decision aids</td>
<td></td>
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<tr>
<td></td>
<td>relevant to his/her patient population</td>
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<tr>
<td></td>
<td>• In second quarter, each physician had to use one in practice</td>
<td></td>
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<tr>
<td></td>
<td>• Metrics tied to the quality improvement bonus</td>
<td></td>
</tr>
<tr>
<td>“Time-Out” After Diagnostic Cath</td>
<td>• Piloting protocol in which physicians take a ‘time-out’ following</td>
<td>Iowa Heart Center at Mercy Medical Center</td>
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<tr>
<td></td>
<td>diagnostic cath to allow for shared decision making between providers,</td>
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<tr>
<td></td>
<td>patient, and family around the best treatment plan (e.g., PCI, CABG,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>medical management</td>
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<tr>
<td></td>
<td>• Enables patient, family to process information and available options in</td>
<td></td>
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<tr>
<td></td>
<td>less stressful environment, truly discuss with physicians</td>
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<tr>
<td>SDM “Hard Stop” Surgery Protocol</td>
<td>• Before an OR will be scheduled for a surgery, physician documents that</td>
<td>Massachusetts General</td>
</tr>
<tr>
<td></td>
<td>the patient meets clinical criteria for procedure and that shared decision-</td>
<td></td>
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<tr>
<td></td>
<td>making process has been completed</td>
<td></td>
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<tr>
<td>ePRISM Individualized PCI Informed Consent</td>
<td>• Web-based application embeds patient-specific estimates of mortality,</td>
<td>Mid-America Heart Institute of St. Luke’s</td>
</tr>
<tr>
<td>Forms</td>
<td>bleeding, stenosis into individualized informed consent forms for PCI</td>
<td></td>
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<tr>
<td></td>
<td>candidates</td>
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<td></td>
<td>• Graphics, bar chats easy for patient to interpret, support conversation</td>
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<td></td>
<td>between provider and patient on optimal treatment choice</td>
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<tr>
<td></td>
<td>• Individualized informed consent forms with patient-specific risk</td>
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<td></td>
<td>associated with greater patient participation in consent process,</td>
<td></td>
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<tr>
<td></td>
<td>reduced anxiety</td>
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</tbody>
</table>

Source: Butcher L, *Hospitals and Health Networks*, May 2013, 26-31; Mercy Medical Center, Des Moines, IA; St. Vincent’s Hospital and Health System, Indianapolis, IN; St. Luke’s Hospital, Kansas City, MO; Cardiovascular Roundtable interviews and analysis.
Empowering Patient to Be Responsible in Own Care

PinnacleHealth’s HF Contract Setting Clear Expectations for Patient Role

Nurse, Patient Adopting Mutual Accountability for Care

• Supplements education, provides framework to engage patients in conversation on care goals
• Patient completes in own words, with nurse’s guidance
• Patient, family take copy home

Hardwiring Patient Compact Into Care Pathway

• Nurses must document conversation, include signed contract in patient record
• Managers regularly audit to ensure completion, hold nurses accountable for adherence

Case in Brief: PinnacleHealth

• Three-hospital health system based in Harrisburg, Pennsylvania
• Recognized importance of engaging, activating patients, to support high-quality outcomes post-discharge, reduce risk of readmission
• HF Patient Contract completed jointly by nurse, patient, family prior to discharge, to ensure patients understand role in care, confirm expectation of participation in self-management

PinnacleHealth HF Patient Agreement

My doctor has diagnosed me with heart failure.
I know I must make adjustments to my daily routine.

I promise to take ____ (my water pill) every day. If I cannot take my pill for any reason, I will call my doctor.

I promise to eat a heart healthy diet. For me, this means that I will eat:
MORE ______________________________________________________ and
LESS _______________________________________________________.

I know my heart failure is worse if __________________________________________.
I will call my doctor if my weight equals _______________. My normal body weight is _______________.

It’s important to me to work with my doctor to manage this disease. I want to succeed and be symptom-free as much as possible. For me, I know I’m having a good day when: ____________________________.

In the next few weeks, I want to ____________________________________________.

In the future, I’d like to talk more about ________________ with my doctor and my heart failure team.

I know I have people to help me. I can call xxxx-xxxx (The Heart Failure Clinic @ Pinnacle Health) when I feel I need help. If I’m having a medical emergency, I will call 911.

I promise to take good care of myself, so I can live life to the fullest.

Patient: _____________[Signature]_______________ _____[Printed]_______ __[Date]__ __[Time]____

Note: Please see the Appendix for an example of a CABG patient compact.
Element 1: Stratification By Activation Level

Fairview Using Algorithm to Identify Patients at Risk of Non-Compliance

Tool in Brief: Patient Activation Measure Assessment

- Developed at University of Oregon
- 13-question survey gauges patient’s skill, beliefs, confidence, in managing own health
- Produces PAM\(^1\) score of 1-100, corresponds with four levels reflecting developmental progression toward greater activation
- Multiple studies link high PAM scores with adherence, preventive behaviors, self-management
- Evidence shows that with support and appropriate interventions it is possible to increase PAM score

Fairview Hardwiring Assessment of Activation into Patient Workup

1. Patient completes PAM survey during initial clinic visit, only requires a few minutes

2. Patient categorized into one of four activation levels, documented in record

3. Providers utilize score in ongoing care to provide tailored guidance, target patients at greater risk of non-compliance


\(^1\) Patient Activation Measure.
PAM Questionnaire Yields Valuable Insight

Patient Activation Measure Assessment

1. When all is said and done, I am the person who is responsible for managing my health condition
2. Taking an active role in my own health care is the most important factor in determining my health and ability to function
3. I am confident I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition
4. I know what each of my prescribed medications does
5. I am confident I can tell when I need to go get medical care and when I can handle a health problem myself
6. I am confident I can tell my health care provider concerns I have even when he or she does not ask
7. I am confident I can follow through on medical treatments I need to do at home
8. I understand the nature and causes of my health condition(s)
9. I know the different medical treatment options available for my health condition
10. I have been able to maintain the lifestyle changes for my health that I have made
11. I know how to prevent further problems with my health condition
12. I am confident I can figure out solutions when new situations or problems arise with my health condition
13. I am confident I can maintain lifestyle changes like diet and exercise even during times of stress

Level 1
Believes Active Role Important

Level 2
Confidence, Knowledge to Take Action

Level 3
Taking Action

Level 4
Staying the Course Under Stress

Element 2: Tailored Follow-up

VA San Diego Customizing Care Pathways to Patient Activation Level

Personalizing HF Patient Care Goals, Interventions

**Level 1: Low Activation**
- Understand Importance of Self-Management
- Establish role in self-care

**Level 2: Low Activation**
- Strengthen Confidence & Knowledge
- Understanding HF (weight, diet, activity)
- Discuss lifestyle behaviors
- Medication education

**Level 3: Medium Activation**
- Develop Skills & Change Behavior
- Set behavioral goals
- Identify barriers & reinforcers
- Track changes (e.g., weight)

**Level 4: High Activation**
- Maintain Skills & Behavior Under Difficult Situations
- Identify resources for support
- Discuss plan for different situations
- Plan to track progress

Goals discussed at each meeting, phone call with patient; progress discussion as activation increases

Distinct Tactics Build Activation at Each Stage

NPs Targeting Discussions Based On Patient’s Ability to Comprehend

Sample NP Interventions for Each Level of Patient Activation

Level 1
- Watch video on living with HF
- Explore possible behaviors to try, help patient choose

Level 2
- Remind how, when to contact PCP, case manager
- Explain BNP, review patient’s own levels
- Discuss medications, purpose of each
- Help patient learn to adjust plans for behavioral change

Level 3
- Link symptom improvement to behavior (e.g., lower salt intake with less shortness of breath)

Level 4
- Identify ‘difficult times’ for patient (e.g., holidays, eating out) establish a plan for each
- Reinforce good behaviors, planning skills

Increasing Activation

Tailoring Care by Activation a Successful Approach

Personalized Interventions Improving Activation, Reducing Readmissions

**Patient Activation Across Time**

*Mean PAM Score*

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>3 Months</th>
<th>6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care</td>
<td>61.3</td>
<td>62.8</td>
<td>64.4</td>
</tr>
<tr>
<td>Tailored Interventions</td>
<td>62.1</td>
<td>67.9</td>
<td>71.5</td>
</tr>
</tbody>
</table>

**Number of Readmissions at Six Months**

*Mean Per-Patient Readmissions*

- Usual Care: 0.32
- Tailored Intervention Model: 0.21

Teach-Back Method Becoming Status Quo

A Foundational First Step in Enhancing Discharge Education

Resources Supporting Implementation of Teach-Back Method

**Cardiovascular Roundtable**
- *Reducing Preventable Readmissions*

**External Resources**
- National Patient Safety Foundation: “Ask Me 3” Program

**Nursing Executive Center**
- *Key Learner Identification*

**Society of Hospital Medicine: “Teach-Back Process”**

**Iowa Healthcare Collaborative:** Teach Back Basics Toolkit

Element 1: Group Discharge Education

South Nassau Reinforcing Post-Discharge HF Instructions in Group Setting

**Bedside Discharge Instruction Delivery**
- Nurses review discharge instructions individually with all HF inpatients, family
- Leverage teachback to ensure comprehension

**HF Group Discharge Session**
- Voluntary for HF patients
- Held in comfortable group education room, directly after discharge from inpatient bed
- CV nurse, dietician, home care staff, reinforce self-management strategies

**Patient, Family Feedback**
- Brief four-question survey
- Evaluates satisfaction, level of comprehension
- Feedback incorporated into future sessions

**Key Topics Addressed**
- Explanation of disease
- Behavior modification
- Importance of compliance
- Symptom surveillance, when to call physician

**An Efficient Format**
- 60 Minute session
- Average number of patients, family members attending

Both Effective and Efficient

Group Approach Elevating Experience, Improving Outcomes

Benefits of Group Discharge Sessions

- Additional opportunity to reinforce post-discharge instructions before patient leaves hospital
- Calmer atmosphere than at bedside, patients more likely to retain information
- Patients meet others with HF diagnosis, comforted to know not alone, share stories
- Efficient format for nurses, staff leading program

Increased Comprehension Leading to Readmission Reduction

Percent of HF Patients Readmitted to Same Hospital Within 90 days

- Standard Care Patients: 32%
- Group Discharge Education Participants: 18%

Element 2: Automated Education

Case 1: Mayo iPad App Empowers, Educates CV Surgery Patients

**MyCare iPad App**

- CV surgery patients, family given iPad upon admission
- Nurse provides 20 minute orientation of MyCare app
- Pushes personalized education, tasks to patient throughout stay to optimize recovery, prepare for discharge
- Special content for family to review while patient in surgery

**Four Domains of MyCare’s Personalized Recovery Plan**

- **Daily Care Pathway**
  Provides transparency into daily care plans, clinical milestone in recovery, patient goals

- **Interactive Education**
  Activities specific to each day, prepare patient to self-manage post-discharge; quizzes assess understanding, retention

- **Drivers of Recovery**
  Self-assessments of pain, participation in recovery tasks (e.g., tracking ambulation)

- **Post-Discharge Planning**
  Helps patients, family know what to expect after discharge, anticipate unique patient needs

Source: Mayo Clinic, Rochester, MN, Cardiovascular Roundtable interviews and analysis.
Attention to Detail Resulting in Successful Approach

Pilot Program Demonstrates Impressive Impact on Patient Engagement

Key Characteristics Supporting Success

Personalized
- Education based on individual recovery progress, quiz scores
- Clinicians monitor progress, intervene as needed

Automated
- Pushes content or tasks to patients based on stage of care plan, specific events of the day
- Returns patient to where they left off

Accessible
- Accommodates needs of elderly, those with limited technology experience
- All content delivered via video as well as audio in first two days post-surgery, when patient vision is impaired

Influencing Patient Experience

85% Average amount of content completed by each patient in pilot
90% Percent of patients in pilot indicating they were highly satisfied with tool on post-discharge survey

Additional Benefits

Lower LOS

Reduced percentage of patients discharged to nursing facilities

Source: Mayo Clinic, Rochester, MN, Cardiovascular Roundtable interviews and analysis.
Key Takeaways

Encouraging Patient Activation

1) Shared decision making between a patient and physician represents a significant opportunity to increase activation and provide higher-value care. CV programs should leverage decision aids to support discussions between physicians and patients on treatment decisions for preference-sensitive conditions, and ensure care pathways reflect patient beliefs and desires.

2) Patient contracts engage patients in their own care by clearly outlining self-management responsibilities, and shared goals between provider and patient. This simple, low-cost strategy encourages discussion between nurse and patient in setting expectations for both parties in maintaining care post-discharge.

3) A ‘one-size-fits-all’ approach for building patient engagement is not sufficient; care interventions must be tailored based on level of activation to achieve optimal results. Programs have a significant opportunity to optimize interventions by first stratifying patients by level of activation, and then tiering care pathways appropriately.

4) Augment foundational teachback techniques with more intensive, individualized delivery of discharge instructions throughout the entire patient stay. There is significant opportunity to empower patients to self-manage while still within the four walls of the hospital, through group discharge education reinforcement sessions and industry or homegrown tools delivering education throughout the recovery process.

Source: Cardiovascular Roundtable interviews and analysis.
Patients Often Non-compliant with Recommendations

Leading to Poorer Quality, Greater Expense

Compliance to Anti-platelet Therapy

*Six Weeks After AMI, n=2,487*

- 75% Compliant
- 25% Non-compliant

Unplanned Readmission Within Six Weeks

- Low Adherence: 11.6%
- Medium Adherence: 9.1%
- High Adherence: 8.1%

Costs for Adherent Patients

*As Compared to Average Patients*

- Dyslipidemia: ($1,860) vs. $601
- Hypertension: ($4,337) vs. $429
- Heart Failure: ($8,881) vs. $1,058

Reduced Annual Spending vs. Pharmacy Costs

Source: Roebuck M, et al., *Health Affairs* 2011, 30: 91-99; Matthews R, JACC, 59 (13); Cardiovascular Roundtable research and analysis.
Hardwiring Referrals to Cardiac Rehab

Case 1: Automated Referral Pathways for Select DRGs at Regions

**Referral as Default**
- AMI order set includes cardiac rehab automatically checked
- Cardiac rehab specialist reviews patient to ensure no contraindications

**Logistics**
- Specialist discusses rehab with patient and family
- Discerns most convenient time for appointment

**Appointment Set**
- For rehab within health system, appointment made at bedside
- Patient leaves hospital with details set

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**AMI Patients Receiving Rehab Referrals Post Discharge**

- National Average: 18%
- Regions Hospital: 78%
  - 60% higher

**Small Changes, Large Outcomes**

“We are helping our patients transition more effectively to the outpatient setting. The slight changes we implemented will make a significant difference in the patient outcomes.”

*Vice President of Cardiovascular Services & Quality Regions Hospital*

Source: Regions Hospital, St. Paul, MN; “Improving Care Coordination by Streamlining Patient Referrals,” Regions Hospital, St. Paul, MN, September, 2010; Cardiovascular Roundtable interviews and analysis.
Variations on the Theme

Reducing Time-to-Appointment and Scheduling for Additional Conditions

**Case 2: Earlier is Better at Mayo**

148 NSTEMI and PCI Patients

- **Cardiac Rehab Orientation**
  - 35 Days
  - 10 Days

**Case 3: Mercy Medical Targeting Surgical, Interventional Patients**

- Scheduled follow-up appointments for surgical, interventional patients 7-10 days post-discharge
- Patients felt well enough from procedure that they would not return

During discharge, nurses now automatically schedule 3-day follow-up visit with AP

**Percentage of Patients Attending 3-Day Follow-Up**

- 41% Attended
- 59% Attended
- 23% Attended
- 77% Attended
- 10% Attended
- 90% Attended

Source: Pack Q. et al., Circulation, 2013, 127:349-355; The Mayo Clinic, Rochester, MN; Mercy Medical Center, Des Moines, IA; Cardiovascular Roundtable interviews and analysis.
Element 1: Motivational Interviewing

Extending Accountability Beyond Four Walls

Percentage of Studies Comparing Motivational Interviewing to Traditional Care

- 80% Outperformed
- 20% Same or Underperformed

CHD Risk Score\(^1\) Pre- and Post-Motivational Interviewing

- Mean, n=35, p<0.001
  - Before: 74.3
  - After: 63.8

Defining Motivational Interviewing

“Motivational interviewing focuses on an individual’s current interests and concerns, respects and honors a person’s autonomy to choose his or her own care, and is a collaborative, not prescriptive, approach in which the counselor evokes the person’s internal motivation and resources for change.”

American Journal of Health-System Pharmacy

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1) CHD risk score derived using modified Framingham risk score and an age- and sex-specific percentile score.

Note: For additional information on post-discharge support, see Reducing Preventable Readmissions and Mastering the CV Care Continuum.
Understanding What Drives Patients at Carolinas

Learning Motivational Interviewing Skills

- 8-hour training course
- Attended by case managers, social workers, nurses
- Agenda includes:
  - Introduction to Motivational Interviewing
  - Application of Motivational Interviewing
  - Clinical Skills Training

Interviewing Techniques

Nurses Trained to Ask Appropriate Questions…

Before: “Can you pay for your medication?”
After: “Most people have trouble paying for their medications—is this something you might struggle with as well?”

Ask Me 3™ Patient Education Program

…Patients Taught to Do the Same in Return

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Source: Carolinas HealthCare System, Charlotte, NC; Cardiovascular Roundtable interviews and analysis.
Element 2: Virtual Visits

Providing Remote Post-Discharge Care at Carolinas

- 25% of patients who could benefit from transitional care were not captured because they lived in remote area
- Piloting virtual visits
- Teams of physicians, APs, RNs, pharmacists, social workers, dietitians remotely join visit in patient home or at local cardiology office

Measuring the Impact

<table>
<thead>
<tr>
<th>Number of virtual visits in 4 months</th>
<th>Readmission in 4 months</th>
<th>Patient satisfaction¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

1) Using questions similar to Press Ganey survey question used in the clinic.

Source: Carolinas HealthCare System, Charlotte, NC; Cardiovascular Roundtable interviews and analysis.
Element 3: Automated Follow-Up

Plethora of Options Flooding the Market

<table>
<thead>
<tr>
<th>Considerations for Automating Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Functionality</td>
</tr>
<tr>
<td>• Electronic educational material</td>
</tr>
<tr>
<td>• Software for patients to self-manage, track progress against goals</td>
</tr>
<tr>
<td>• Apps that send reminders or medications, adherence to lifestyle recommendations</td>
</tr>
<tr>
<td>• Tracked biometric data, transmitted to caregiver</td>
</tr>
<tr>
<td>• Point-of-care alerts for gaps in preventive, chronic care</td>
</tr>
<tr>
<td><strong>2</strong> Method</td>
</tr>
<tr>
<td>• Phone call</td>
</tr>
<tr>
<td>• Text message</td>
</tr>
<tr>
<td>• Smartphone app</td>
</tr>
<tr>
<td>• Technology platform (purchased/developed by hospital)</td>
</tr>
<tr>
<td>• Hardware (e.g., pill bottle with reminder alerts)</td>
</tr>
<tr>
<td>• Virtual consults</td>
</tr>
</tbody>
</table>

There’s an App for Everything

17K Mobile health apps available in major app stores

160 Number of Smartphone apps for medication adherence, 2013

Select Technologies Offering Longitudinal Follow-Up

• iCare Passport
• WellDoc
• Postwire
• VG0 Communications

• Pipette
• Ginger.io
• txt4health
• Emmi Solutions

3 Responsible Party

<table>
<thead>
<tr>
<th>Patient-directed</th>
<th>Caregiver-directed</th>
</tr>
</thead>
</table>

**Study in Brief: High Risk Patients Benefit Most From the SMS-Based Intervention**

- Study published in *Hypertension*, conducted by Jagiellonian University Medical College in Poland
- Tracked 2,055 hypertension patients over 6 months to evaluate the efficacy of weekly or twice-weekly text messages on outcomes
- Messages contained a reminder about taking medication, and information on lifestyle modification, self blood pressure control, and drug adherence

**Impact of Weekly SMS\(^1\) Reminders at 6 Months**

- **Medication Adherence**
  - Before Reminders: 50%
  - After Reminders: 93%

- **Reduction in Blood Pressure Recorded, mmHg**
  - Diastolic: 10
  - Systolic: 17

- **Change in Lifestyle**
  - Smoking Cessation: 11%
  - Salt Reduction in Diet: 56%
  - Increased Physical Activity: 57%
Reminding Patients Through Automated Voice Alerts

Hackensack Partnering for More Intense Patient Follow-Up

Piloting Automated Follow-Up
- Aimed to gauge impact of automated follow-up on readmission rates
- Included 100 HF patients
- Four hospitals participated

EmmiTransition™ a Comprehensive Approach
- Automated, interactive system of outreach tools to improve care transitions
- Includes online education, engagement of patients’ personal contacts and caregivers through “circle of care” phone calls, tools to report feedback to hospital
- Interactive voice response phone called patients for 45 days after discharge, with reminders to schedule appointments, take medications, complete lifestyle recommendations

Pilot Yielding Impressive Results
- Red flags caught that could otherwise impact patient satisfaction, outcomes
- Reduction in all-cause HF readmission rates

Reducing Co-pays to Improve Medication Adherence

Minimizing Cost Sharing Leading to Reduced Utilization

Meta-analysis of Value-Based Insurance Design

Review of 13 articles evaluating value-based insurance design

25%-100% reduction in copay for diabetic, cardiac medications

3%
Average improvement in adherence at end of first year

Selectively Reducing Utilization

Reductions in statin, clopidogrel copayments for diabetes, vascular disease

Relative Reduction in Utilization Rates for Patients with Lower Copays as Compared to Control

<table>
<thead>
<tr>
<th></th>
<th>Clopidogrel Users</th>
<th>Statin Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Visits</td>
<td>0.87</td>
<td>0.8</td>
</tr>
<tr>
<td>Hospital, ED Admissions</td>
<td>0.89</td>
<td>0.9</td>
</tr>
</tbody>
</table>


1) Insurance design which “attempts to improve the quality of care by selectively encouraging or discouraging the use of specific health care services, based on their potential benefit to patients’ health, relative to their cost.”
Offering Financial Upside to Improve Compliance

UPenn Developing Lottery for Warfarin Adherence

Testing a Warfarin Lottery

- Volunteers from Anticoagulation Management Center
- Used Informedix Med-eMonitor™ System with daily medication reminder

Pilot 1

- 10 participants
- Lottery with daily expected value of $5
- When subjects opened pill compartments properly, entered into daily lottery
- 1 in 5 chance of winning $10, 1 in 100 chance of winning $100

Pilot 2

- 10 participants
- Lottery with daily expected value of $3
- When subjects opened pill compartments properly, entered into daily lottery
- 1 in 10 chance of winning $10, 1 in 100 chance of winning $100

Percent of Incorrect Pills Taken

<table>
<thead>
<tr>
<th>Before</th>
<th>Pilot 1</th>
<th>Pilot 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.0%</td>
<td>2.3%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

Percent of Out-of-Range INRs

<table>
<thead>
<tr>
<th>Pilot 1</th>
<th>Pilot 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>12%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Source: Volpp K, et al., BMC Health Services Research, 2008, 8:272; Cardiovascular Roundtable research and analysis.
Keeping Patients in Network

Many Opportunities to Slip Through the Cracks

Retaining Patients Now More Critical

Flashpoints for Patients to be Lost to Follow-Up

Delay in scheduling visit, procedure

Lack of communication between various specialists, back to PCP

Uncoordinated discharge; no connection back to clinic, rehab

Hospital Responsibility Under Risk-Based Payments

Quality outcomes

Long-term costs

Track data across continuum

Prevention

Capturing “Share of Wallet”

- Percentage of patients’ health care dollar spent within a particular hospital, system
- Patient stays within clinical program for related care
- System becomes patient’s preferred provider
- Patient recommends system to friends, family

Source: Cardiovascular Roundtable research and analysis.
Patient Portal Key to Linking Patients and Hospital

Case 1: Preventing Leakage via PHR at Kaiser

Kaiser Permanente “My Health Manager”

System Capabilities

- Check symptoms
- Book appointments
- Email physicians
- Renew prescriptions

Lab tests viewed online: 33 M
Emails sent by patients: 13 M
Prescription refill requests, 30% of all refills: 12 M
Requests for appointment, reducing no-show rate by 33%: 3 M

2.6 x
More likely to stay with Kaiser if using PHR

Study in Brief

- Three-year study of 394,214 Kaiser Permanente Northwest members
- PHR (My Health Manager) was third strongest predictor of retention, preceded by illness burden and membership tenure


1) Personal health record.
Note: Results from 2012.
Portal the Avenue for Ongoing Management

Case 2: Developing Chronic Care Capabilities at Geisinger

Chronic Condition Management Patient Portal
- Offer resources to educate, help manage symptoms
- Currently have platforms for CHF, asthma, diabetes, hypertension

Components of CHF Platform

Clinical Status Information
- Test results
- Medications
- Section to track weight if assigned by provider
- Preventive care needed

News and Education
- Educational videos on pacemakers, angiograms, AF\(^2\), CAD\(^3\), CABG
- Information on dealing with illness including coping strategies, managing stress
- Information on medications, warning signs, dietary considerations

Customized Action Plans
- Providers able to develop patient-specific action plans accessible via the portal
- Allows provider and patient to track progress toward care goals

Source: Geisinger Health System, Danville, PA; Cardiovascular Roundtable research and analysis.

33% Percentage of ongoing patients using portal

207 K Number of active users

57 K Number of unique users per month

1) Personal health record.
2) Atrial Fibrillation.
3) Coronary artery disease.
Element 1: Shared Medical Appointments at Carolinas

- Nurse educates, answers questions
- Social worker facilitates; tech acts as scribe
- Physician examines each patient
- Dietician educates patients; dietician, pharmacist follow-up with one-on-one appointments

Percentage of Family Physicians Conducting Group Visits

- 5.7% in 2005
- 12.7% in 2010

Resulting in High Patient Satisfaction

And Increasing Physician Productivity

Percentage of Respondents Rating “Good” or “Very Good”

November 2012-September 2013

100% Understanding of Process

100% Overall Care

100% Likelihood to Return

Number of Patients Seen by Physician

- Clinic: 5
- Shared Medical Appointment: 10

Source: Carolinas HealthCare System, Charlotte, NC; Cardiovascular Roundtable interviews and analysis.
Facilitating Patient-Patient Interactions at University of Michigan

CV Support Groups Address Range of Patient Populations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amputation/Limb Loss</td>
<td>UM Community Amputee Network (U-CAN) (for amputees and family members)</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>ICD Connection (Adult Group)</td>
</tr>
<tr>
<td>Arrhythmia</td>
<td>Young ICD Connection (for children, teen, and young adult ICD recipients &amp; their families)</td>
</tr>
<tr>
<td>Heart Transplant/VAD¹</td>
<td>Heart Transplant &amp; VAD (Pre- &amp; Post-Treatment) for transplant and VAD patients, and their families</td>
</tr>
<tr>
<td>VAD</td>
<td>VAD Patient &amp; Family Support Group</td>
</tr>
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<thead>
<tr>
<th>Topic</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>VAD</td>
<td>Adult Heart Transplant &amp; Center for Circulatory Support</td>
</tr>
</tbody>
</table>

Ambassador Programs Offer Added Support

- ICD Ambassador Program: recipient matched to new ICD recipient, provides guidance, support through recovery, care management
- Discharge Ambassador Program (in planning process): volunteers will assist with providing special “send off” from hospital for CVC patients, family; pair each patient, family with discharge ambassador

- Groups meet monthly, quarterly
- Facilitated by social workers, nurses
- Select groups host annual day-long conference with breakout sessions for teens, parents, men, women, spouses
- Young ICD Connection complemented by Facebook group

Source: The University of Michigan Frankel Cardiovascular Center, Ann Arbor, MI, available at: http://www.med.umich.edu/cvc/pat_vis/support_groups.html, accessed June 20, 2013; Cardiovascular Roundtable interviews and analysis.

¹) Ventricular assist device.
Key Takeaways

Ensuring Compliance and Loyalty

Promoting Adherence

1) **Schedule follow-up appointments while patients are still in the hospital.** Identify care needed after the patient leaves the hospital, schedule the next appointment before the patient leaves, and monitor patients to ensure they return for follow-up care.

2) **Continue to support patients after discharge.** Maintain longitudinal care by conducting motivational interviewing, and selectively leverage automated systems and virtual visits to remind patients to adhere to medication and lifestyle recommendations.

3) **Consider financial incentives to improve patient compliance.** Though still in early development, financial incentives in the form of reduced co-pays, improved coverage, free medications, premium reductions and other “prizes” have shown to be effective methods for improving patient adherence.

Keeping Patients in Network

4) **Carefully design EMR to engage patients, thereby boosting their attachment to the hospital.** Designed with capabilities for interactivity (e.g., prescription refills, emailing caregivers, viewing lab results, scheduling appointments), patient portals can increase loyalty to the organization and prevent patient loss to follow-up.

5) **Encourage patients to develop rapport with one another.** To help develop personal relationships between patients that are associated with the hospital, offer shared medical appointments, provide in-person and online support groups for patients with like conditions, and pair new patients with previous satisfied patients in “mentorships.”

Source: Cardiovascular Roundtable interviews and analysis.
Road Map

1. Building the Business Case for Patient-Centered Care

2. Imperatives for Engaging Patients Across the Continuum

3. Coda
Putting the Patient First

Envisioning Patients at the Center of Health Care

- Access to Full Range of Services
- Personalized Care
- Collaborative Care
- Access to Information
- Convenient Sites of Care

The Blockbuster Drug of the Century: An Engaged Patient

“…It’s surprising that it has taken us this long to focus on patient engagement because the results we have thus far are nothing short of astounding. If patient engagement were a drug, it would be the blockbuster drug of the century and malpractice not to use it.

Engagement is just the very first step of what I think will become a new science of behavioral economics and behavior change in healthcare.”

Leonard Kish

Source: Cardiovascular Roundtable research and analysis.
CV Patient Experience Discussion Guide

1. Do you encourage patients to participate in shared decision-making? How have you gained physician buy-in for shared decision-making?
2. How do you activate patients to participate in their own care across time?
3. Do you utilize patient compacts?
4. Do you assess patients by level of activation and tailor follow-up care accordingly?
5. How are you empowering patients to self-manage at discharge?
6. How do you encourage patients to remain compliant to treatment recommendations after discharge?
7. Are you hardwiring follow-up appointments?
8. How do you provide post-discharge support?
9. Are you leveraging technology to assist patients in post-discharge care and to link them to the organization?
10. How do you ensure patient loyalty to the organization?
11. Are you working with payers to provide patient incentives to remain compliant and loyal?
12. How are you optimizing your patient portal?
13. Do you offer opportunities for patient-patient interaction, e.g. shared medical appointments and online support communities?

Source: Cardiovascular Roundtable research and analysis.