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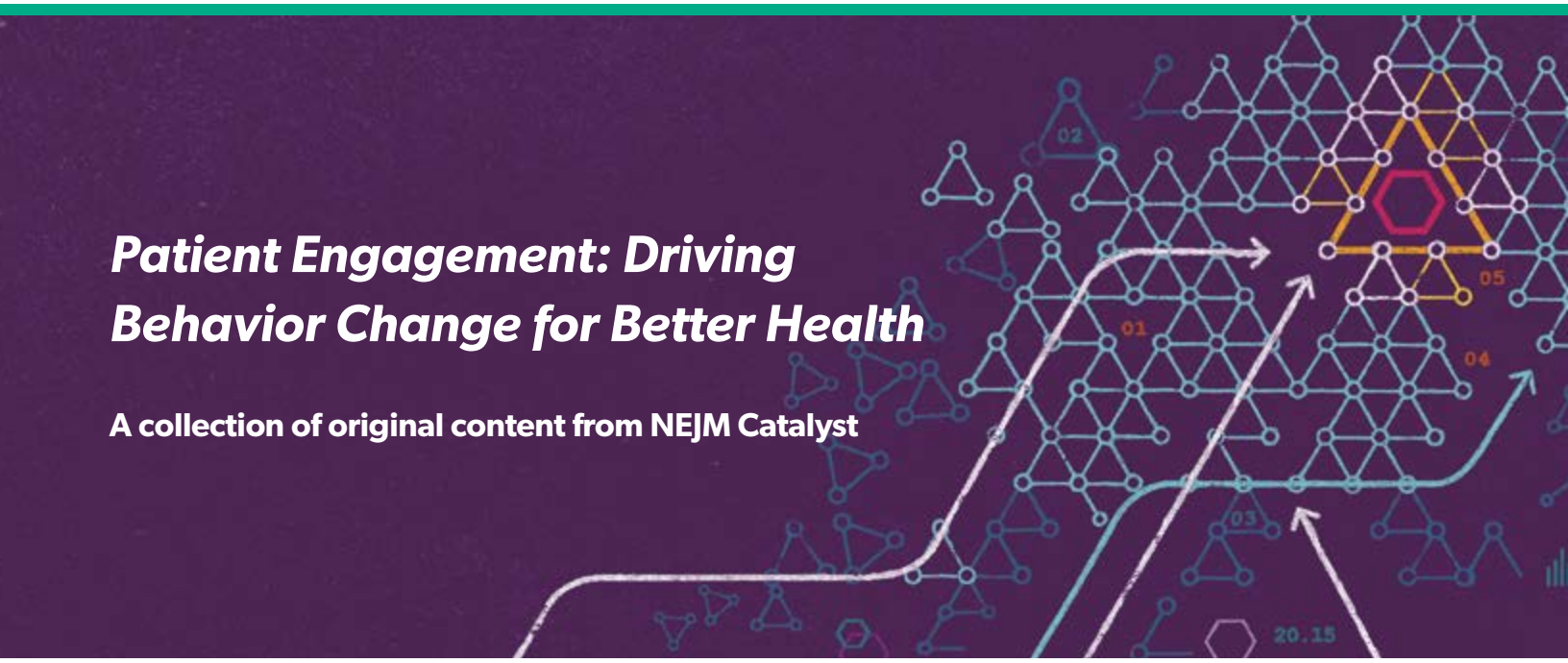

Patient Engagement: Driving Behavior Change for Better Health

A collection of original content from NEJM Catalyst

NEJM GROUP

NEJM Catalyst

November 2016

Dear Colleague,

NEJM Catalyst was launched by NEJM Group in late 2015 to bring health care executives, clinician leaders, and clinicians together to share innovative ideas and practical applications for enhancing the value of health care delivery. Through daily digital publication and quarterly live-streamed events, NEJM Catalyst offers original content, expert dialogue, and insightful analysis from a network of top advisors and experts.

Patient engagement has emerged as a mantra for many health care professionals, a welcome concept for patients and their families, and, sometimes, a buzz phrase that obscures an essential fact: what patients really want is health rather than health care. NEJM Catalyst has worked with Kevin Volpp, MD, PhD, who is Director of the Center for Health Incentives and Behavioral Economics at the Perelman School of Medicine of the University of Pennsylvania, to create new and important contributions on patient engagement. The enclosed collection of original content from our site includes an account of how Kaiser Permanente addresses social needs to engage the 1% of its patients who incur 23% of its total health care spending; a case study of how outpatient pharmacy services can ease the lives of parents of sick children; a blog post on how patients prefer their providers to dress; a first-person account of the requirements to become a "patient-researcher"; an interview with the Chief Experience Officer of Cleveland Clinic; a chart that shows at a glance how behavioral interventions can have very different effects in different portions of the population; and an NEJM Catalyst Insights Report on patient engagement, drawing from our proprietary survey.

We invite you to join NEJM Catalyst and stay informed on how patient engagement can fulfill its promise.

Edward Prewitt
Editorial Director, NEJM Catalyst

781.893.3800 | NEJMCUST@NEJM.ORG
860 WINTER STREET, WALTHAM, MA 02451-1413 USA | catalyst.nejm.org

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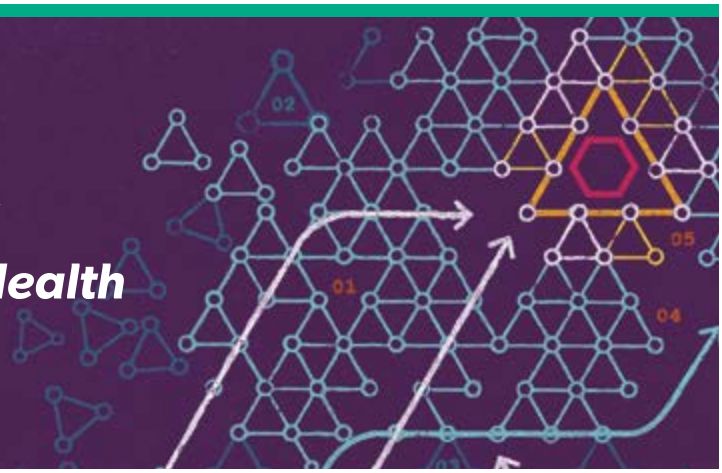

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Health Care That Targets Unmet Social Needs

Article

Nirav R. Shah, MD, MPH, Artair J. Rogers, MS & Michael H. Kanter, MD

Kaiser Permanente

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Kaiser Permanente, the nation's largest integrated health delivery organization, launched its Total Health initiative in 2014 to promote healthy eating and active living among our members. We have now begun to bolster that effort by aiming to target our members' unmet social needs as part of their overall health care. After all, social, environmental, and behavioral factors account for an estimated 60% of health, compared with just 10% from factors traditionally defined as "clinical." And research shows that nations that focus on food insecurity, housing, transportation, and other "nonmedical" factors spend less overall on health care while improving quality and quantity of life.

> *We believe that adopting a "whole patient" perspective for our high-cost, high-need patients will give us the best chance of improving their health outcomes."*

The most sensible starting point in addressing unmet social needs is, of course, the costliest patients — the roughly 1% of our members (40,000 of the more than 4 million in southern California) who incur 23% of our total health care spending. Evidence shows that most health care strategies fail the top 1% of spenders — the high-cost, high-need super-utilizers or, to use Atul Gawande's term, "hot spotters."

To meet these patients' needs, we recognize that we must do more than provide top-quality care in hypertension control, immunization, cancer screening, cardiovascular disease management, asthma, diabetes, and other clinical areas — all of which have garnered us national recognition. So we set out to develop a scalable approach that, by targeting the social determinants of health, improves patients' overall well-being while complementing our system's current offerings.

That doesn't mean that Kaiser Permanente should, for instance, build affordable housing for homeless people who enter our doors. But it does mean taking on the responsibility for the full scope of our patients' needs, consistent with our social mission and business imperative to improve the health of the communities we serve. We believe that adopting a "whole patient" perspective for our high-cost, high-need patients will give us the best chance of improving their health outcomes. To achieve this goal, we aim to partner with existing community resources, identify gaps in linking with those resources, and (in the process) demonstrate the value of directly addressing the social determinants of health.

How We Reach the Neediest Patients

Physicians generally lack the training and resources to fully assess patients' unmet social needs and to identify and work with community-based organizations that can meet them. That task requires a total skill set that only a team-based approach can offer. So, beginning in 2015, Kaiser Permanente partnered with Health Leads, a social enterprise organization that aims "to address all patients' basic resource needs as a standard part of quality care."

With Health Leads' expertise, Kaiser Permanente is developing several initiatives as part of a carefully designed pilot project. The most scalable approach is a call center that proactively reaches out to patients we identify as being at highest risk of becoming super-utilizers (i.e., in the top 1% of predicted utilization according to their illness burden). Trained KP call-center workers cold-call these members to ask about their unmet social needs. So far, we have called 876 members, 69% of whom answer the phone.

The call-center staff person starts by asking the member whether he or she would like to participate in a phone-screening session about social needs that affect health and well-being. If the member agrees (76% of those who pick up the phone do), he or she is asked a set of screening questions, some of which are shown in the table (see next page).

We have found that 78% of screened members have at least one unmet social need (mean, 3.5). Of the people with unmet needs, 74% (or 21.2% of all the members we call) agree to enroll in Kaiser Permanente's Health Leads program, which connects them with existing resources in the community (e.g., food banks, tenants' rights associations) or at Kaiser Permanente (e.g.,

Response Rates to Selected Social-Needs Screening Questions

Question	% Positive
1. Within the past 12 months, "the food I bought just didn't last, and I didn't have the money to get more."	32%
2. Within the past 12 months, "I couldn't afford to eat balanced or healthy meals."	35%
3. Do you worry about having a safe place to live or being homeless?	13%
4. In the past month, have you had concerns about the condition or quality of your housing?	13%
5. Do you have difficulty arranging for transportation to or from your medical appointments?	26%
6. Do you need help finding ways to pay your utility bills?	23%

Data reflect response rates as of 03/04/2016.

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Kaiser Permanente Call Center.

member financial assistance). So far, we have enrolled 186 members in community-based social-needs programs. To ensure quality and patient safety, the call-center team partners with local social-medicine and case-management teams if social needs beyond the call center's scope of services arise.

Enrolled members are called every 10 to 14 days, to further assist them in connecting with resources and to assess how well their needs are being met. We are in the process of analyzing the success of our referrals to outside agencies (e.g., which is the best food bank?) so that we can better understand the resource gaps within a defined geography; develop a community-alignment strategy, in partnership with community-based organizations, to address those gaps; and ultimately increase the number of successful resource connections for our members.

Here's what data from Health Leads show: Of the 25,000 resources across 8 geographies in its database, just 1% of resources account for 50% of successful connections, and 10% of resources account for 90% of successful connections. We aim to start using these findings to emphasize connections with the highest-yield community resources. In addition, in other pilot projects, we are assessing the quality of in-person assessments of social need in various care settings (e.g., ambulatory clinics, home health, inpatient units) and the success of what we call "warm handoffs," whereby clinicians preliminarily identify a patient with a social need and refer him or her to the call center.

Early indicators show a high prevalence of social need among our high-cost, high-need members and suggest likely downstream effects on health care utilization and clinical outcomes."

Few attempts have been made, at scale, to identify and close gaps in social (nonmedical) needs. Our call center — using a well-trained, nonclinical workforce — is a low-cost model for assessing the social needs of patients and helping them navigate available resources. Early indicators show a high prevalence of social need among our high-cost, high-need members and suggest likely downstream effects on health care utilization and clinical outcomes.

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The definition of what counts as health care is expanding. Health care systems can responsibly steward and amplify shared economic, human, and community resources to deliver high-value care within and beyond a provider's walls. Our pilot project at Kaiser Permanente, focusing on patients' unmet social needs, is one concrete step in that direction.

Acknowledgment: Adam Sharp, MD, and Adam Schickedanz, MD, helped to lead this work at Kaiser Permanente, Southern California. We also thank Rebecca Onie, Alexandra Quinn, and Kelly Hall at Health Leads for their insightful guidance — and Arthur Southam, MD, and Raymond Baxter, PhD, for their partnership and leadership.

Nirav R. Shah, MD, MPH
Kaiser Permanente, Southern California

Nirav R. Shah is the Senior Vice President and Chief Operating Officer of Clinical Operations for Kaiser Permanente's Southern California region. Learn more about Nirav R. Shah...

Artair J. Rogers, MS
Senior Consultant, Kaiser Permanente, Southern California

Michael H. Kanter, MD
Executive Vice President and Chief Quality Officer, The Permanente Federation

Improved Patient Experience through Expansion of Pediatric Outpatient Pharmacy Services

Case Study

Abhay S. Patel, PharmD, MS, Jeffrey L. Wagner, PharmD, MPH, BCPS & Larry H. Hollier, Jr., MD, FACS, FAAP

Children's Hospital of Philadelphia
Texas Children's Hospital

Originally published by NEJM Catalyst *http://catalyst.nejm.org/patient-experience-pediatric-outpatient-pharmacy-services/*

Through a "Meds to Beds" program, Texas Children's Hospital (TCH) used its outpatient pharmacy to provide discharge prescriptions and medication counseling at the bedside for 1,008 ambulatory surgery patients over three months. Because of this service, patients' families face significantly fewer challenges in filling prescriptions during their transition home, and they receive focused medication counseling and education. The financial impact of the pilot program was minimal due to the relatively low cost of the medications prescribed after ambulatory surgery. However, we estimate that the hospital could add more than $100 million to its bottom line by aggressively extending the outpatient pharmacy service hospital wide and including specialty medications. Anecdotal evidence suggests that the program reduces readmissions and improves quality of care; we are seeking to quantify those benefits.

KEY TAKEAWAYS

1. Provision of a "Meds to Beds" service for pediatric patients and families is helpful in closing gaps in the care continuum for patients upon discharge.
2. Bedside prescription delivery and pharmacist education can be supported through increased acceptance of commercial prescription insurances and greater 340B participation.

Patients at Texas Children's Hospital (TCH), a 600+ bed freestanding pediatric institution that is the largest of its kind in the country, face challenges getting their prescriptions filled after discharge. Community pharmacies generally lack pediatric pharmacy expertise, which may result in dosing and dispensing errors. (The Institute for Safe Medication Practices cites pediatric dosing error rates of between 15 and 35%.) Also, community pharmacies may not routinely stock medications that pediatric patients need, particularly with compounded suspensions, creating delays in starting prescribed regimens. Despite these challenges, nearly 91% of families surveyed by TCH were filling their child's discharge prescriptions at community pharmacies on their way home from the hospital after ambulatory surgery.

> *Our immediate goal was to ensure that patients had all their medications, along with counseling and instruction on their use, before they left the hospital. This goal required fundamental changes in the operation of our outpatient pharmacy."*

At the same time, the outpatient pharmacy at TCH was an underused resource. It provided prescription services for patients with Medicaid, but did not have relationships with commercial pharmacy benefit plans and, therefore, could not serve a large portion of the patient mix. Even families of Medicaid patients were not always aware that they could fill prescriptions at the hospital's pharmacy. Prescription services were contained within the pharmacy, requiring families to leave the child's bedside to come to the pharmacy and wait to have prescriptions filled. Initially, the hospital's electronic health record (EHR) system was not set up to allow electronic prescribing to the outpatient pharmacy, even though it could transmit prescriptions directly to community pharmacies. This meant that families had to carry paper prescriptions if they used the hospital's outpatient pharmacy.

The hospital realized that the gaps in pharmacy service hindered the goal of providing comprehensive care and equipping families with everything needed to ensure a smooth and safe transition out of the hospital.

The Goal

Our immediate goal was to ensure that patients had all their medications, along with counseling and instruction on their use, before they left the hospital. This goal required fundamental changes in the operation of our outpatient pharmacy. We began with ambulatory surgery patients because these patients are fairly incapacitated at discharge, and forcing a stop at a pharmacy on the way home can be onerous for both the patients and their families. Delivering the prescriptions to the patient's bedside ("Meds to Beds"), with medication counseling by a pharmacist, would eliminate the immediate need to deal with a community pharmacy and improve both continuity of care and the patient experience.

The Execution

We made a thorough assessment of the resources and limitations of our outpatient pharmacy. We issued a questionnaire to a sample of families to assess demand for the proposed service and identify potential concerns. Sixty percent of respondents said they would use the hospital's outpatient pharmacy if they had the option, and 63% either said they had no concerns or did not respond to that question.

We convened a core project team that met weekly and included physician, nursing, and pharmacy leadership. The team routinely engaged family services, patient experience, and patient advocacy staff as well. The team's tasks included:

- *Establishing contracts with commercial insurance plans.* We entered into an agreement with the Community Independent Pharmacy Network (CIPN), which negotiates agreements with insurers on behalf of independent pharmacies. Establishing the CIPN relationship and getting payer agreements in place took about 12 months, after which our pharmacy was able to serve patients covered by all commercial insurers.
- *Coordinating bedside pharmacy services.* Families were offered the new option to have prescriptions filled and delivered to the bedside while they were with their recovering child.
- *Advocating for and executing electronic prescribing of medications from the unit to our own outpatient pharmacy.* Our EHR is set up to send electronic prescriptions to a patient's preferred pharmacy. We put in place a manual process at registration, where families could temporarily select our pharmacy as their preferred pharmacy, enabling electronic prescribing. The system automatically reverted to the patient's original preferred pharmacy after the ambulatory surgery episode of care was complete.
- *Informing key players of new procedures.* Process changes were communicated among the multi-disciplinary team and within the organization.
- *Determining how to collect co-pays.* We adopted a point-of-sale system for collecting co-pays at the bedside via credit card based on our IT department's criteria for end-to-end encryption of transactions and compliance with all requirements for protecting personal credit information.

The Team

The team included the Surgical Director of Patient Experience, nursing leadership, the Director of Pharmacy Services, and several representatives of the pharmacy staff.

The Metrics

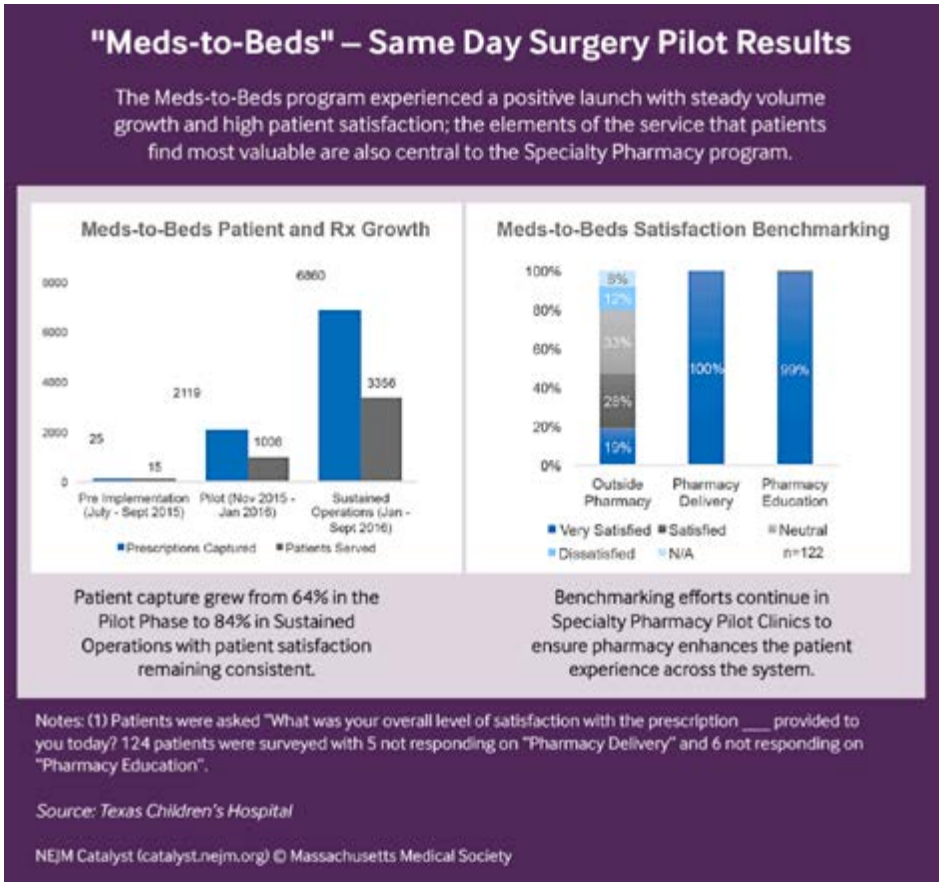
After expanding outpatient pharmacy services to patients with commercial insurance and instituting the Meds to Beds program, our outpatient pharmacy filled 64% of ambulatory surgery patients' prescriptions prior to their discharge, compared with less than 1% before the program. The pharmacy dispensed 2,119 prescriptions for a total of 1,008 patients in the three months after go-live, compared with 25 prescriptions for 15 patients in the three months prior to go-live.

After three months of implementation, the same-day surgery prescription volume made up 24% of the outpatient pharmacy's average workload per month. Most of the prescriptions were analgesics, anti-emetics, post-operative antibiotics, and steroids.

100%

patients and their families Very Satisfied with prescription delivery

When patients and families were surveyed about their participation in the program, 100% said they were "Very Satisfied" with the prescription delivery, and 99% indicated "Very Satisfied" with prescription education provided by the pharmacist. All the participants said they would be very likely to use the service for future visits. (In contrast, satisfaction with previous services rendered by an outside pharmacy was 48%.)



"Meds to Beds" Same-Day Surgery Pilot Results.

Return to TOC

When families were surveyed before the start of the program, they voiced concerns around timeliness, cost, and the pharmacy having the medication in stock. In a follow-up survey after receiving the new service, families most appreciated the convenience and timeliness, as well as the education from the pharmacist.

Next Steps

We plan to expand use of our outpatient pharmacy to other areas of the hospital, particularly services that use more expensive specialty medications, and extend Meds to Beds to our inpatients at discharge. By increasing the number of prescriptions filled at our outpatient pharmacy, we will also be able to leverage additional savings through our participation in the 340B Drug Pricing Program, which requires drug manufacturers to provide outpatient drugs to eligible health care organizations at reduced prices. We are also working to develop functionality within our EHR that will change the patients' preferred pharmacy automatically upon registering for ambulatory surgery, removing the need for a manual change.

Thanks to Jamie Kim, PharmD, Jennifer McCarthy, RPh, Rosa Lopez, Nancy Wong, CPhT, Julianna Fernandez, PharmD, BCPS, CGP, Joseph Bloom, Beth Jones, Rebecca Hanson, Lorianne Classen, Cameron Bisset, Juan Rivera, and Tabitha Rice.

Abhay S. Patel, PharmD, MS
Pharmacy Supervisor, Children's Hospital of Philadelphia; former PGY1/PGY2/MS Health-System Pharmacy Administration Resident, Texas Children's Hospital

Jeffrey L. Wagner, PharmD, MPH, BCPS
Director of Pharmacy Services, Texas Children's Hospital

Larry H. Hollier, Jr., MD, FACS, FAAP
Surgical Director of Patient Experience, Texas Children's Hospital

Physician Attire and Patient Preference: Evidence-Based Guidance for Choosing a Dress Code

Blog Post

Griffin Myers, MD, MBA

Originally published by NEJM Catalyst
http://catalyst.nejm.org/physician-attire-and-patient-preference-evidence-based-guidance-for-choosing-a-dress-code/

Imagine you were opening your very own medical practice from scratch. It would be your chance to build a practice just the way you had always wanted. You would have a lot of decisions to make about things like clinic layout, staffing, electronic health record selection, etc.

One seemingly trivial item you would ultimately arrive at is this: what do you and your colleagues wear to work? We've had to answer a number of questions like that since starting our practice, Oak Street Health, in 2012. Yet the implications of this particular question were more far-reaching than we had first expected.

At first glance, the topic of attire seems, well, superficial — nothing a serious medical professional should consider. But today we practice in an environment with a growing focus on value-based care. What if you were to find out that a physician's attire is measurably important to metrics of patient satisfaction or even to clinical outcomes? The question of attire now becomes more interesting.

> *What clinicians wear to work is a daily choice that reflects our perspective on whether to prioritize patients' preferences above our own."*

I don't mean to suggest that medical attire is a major driver of public health or the health care economy. As one study of physician attire put it, "we should not oversell the importance of attire. While professional appearance might contribute to first impressions, professional behavior is likely to be far more important to patients and families."

Yet attire does matter. Our field of medicine is wonderfully more diverse than in years past, and that means simple guidance on neckties and wristwatches is anachronistic at best. What clinicians wear to work is a daily choice that reflects our perspective on whether to prioritize patients' preferences above our own. That's a topic worth exploring.

With regard to patient satisfaction, the evidence suggests that patients do care about physician attire. Whether you read literature for internal medicine, dermatology, or family medicine, patients appear to have a consistent preference for "professional" attire — i.e., roughly business casual, with or without a tie — with a white coat. A nicely done meta-analysis from 2014 summarizes this research.

Team Frazier, Oak Street Health.

That leaves the issue of clinical outcomes, and here we're stuck with lots of hypotheses and few randomized controlled trials. Since the days of Semmelweis it's been recognized that physician hygiene has implications for transmission of infectious diseases. Scrubs were created precisely for prevention of pathogen transmission in the operating theater, yet today they're worn as much on the subway as in the operating room. The Joint Commission lacks specific evidence-based guidance on whether scrubs must be laundered daily, making them more of a fashion choice than much else. Additionally, neckties and shirt sleeves may act as reservoirs for potentially pathologic agents. In fact, based on this evidence, the United Kingdom's

National Health Service has decreed a controversial "bare below the elbows" policy for hospital-based providers. In other words, while the evidence is less than robust, hypotheses around transmission of infectious disease have led clinicians to wear scrubs and short sleeves, lose the neckties and wristwatches, and wash our white coats as often as we can.

So what did we do at Oak Street Health as we started our practice? We were compelled by the data that patients prefer professional attire and white coats. We were also impressed by the possibility of reducing infectious disease in our population of older adults. Lastly, we considered something else entirely: the cost for our non-physician colleagues to self-fund a wardrobe for the clinic. We ultimately landed on practice-issued scrubs for the entire care team, with personalized embroidered white coats for our licensed providers. This ensures a professional, business casual appearance that may also reduce infection transmission. That the scrubs are provided by our practice is a perk for our teams.

In the end, we took an approach shared by many hospitals and outpatient practices around the world. That's an encouraging finding, because it suggests that most organizations are operating in accordance with the best evidence. It means we're in good company at Oak Street, and armed with these data we have a far simpler decision as we get dressed each day.

Griffin Myers, MD, MBA
Founder and Chief Medical Officer, Oak Street Health; Adjunct Instructor of Emergency Medicine, Northwestern University Feinberg School of Medicine

Patient-Researchers and Physician-Consultants Confront Chronic Disease

Article

Anna McCollister-Slipp

Scripps Translational Science Institute; Galileo Analytics

Originally published by NEJM Catalyst
http://catalyst.nejm.org/patient-researchers-physician-consultants-confront-chronic-disease/

I consider myself a digital health native.

For most of the past 30 years, I've been using digital tools and data-generating devices to make daily, often hourly, decisions about how much of a potentially fatal drug I should administer. That drug, insulin, keeps me alive. But get the dosage wrong by even the smallest of amounts, and there are very real and immediate consequences. Best-case scenario: You might tank your afternoon meeting or do poorly on that big algebra test. Worst-case scenario: you're dead or disabled — an all-too-frequent occurrence among those of us with Type 1 diabetes.

Because of the demands of managing insulin, the role of my physicians has changed dramatically. Once, they were the source of all knowledge and guidance. Now, I consider my physicians to be consultants. They play a critical role in enabling me to manage my diabetes. But, like it or not, I am the executive in charge of maintaining my health and managing my disease.

"Because of the demands of managing insulin, the role of my physicians has changed dramatically. Once, they were the source of all knowledge and guidance. Now, I consider my physicians to be consultants."

The responsibility for dosing my insulin rests on me, because it must. Neither my doctor nor I have much choice in the matter. The "same dose every day" insulin regimen is largely — and fortunately — a thing of the past. Most of us who use insulin to stay alive make the decision many times a day about how much

we need and when, based on our own measurements, understanding, and experience of life with the disease. Our doctors give us guidance, and we may go to diabetes educators to receive training and advice. But the day-in, day-out decisions are all on us, the diabetes patients.

Anybody reading this who knows anything about type 1 diabetes shouldn't be surprised. Since the introduction of home glucose meters in 1983, responsible physicians have encouraged and empowered patients to accept and embrace this reality. As personal use devices have become more sophisticated and insulin has improved, this trend has escalated, and many patients are living safer, longer, less restrained lives as a result.

For me, though, disease management doesn't stop with insulin. After decades of life with difficult-to-control diabetes, I have an array of complications — eye, kidney, and nerve disease — as well as a few common comorbid conditions to help make things more interesting. To manage this, I take 14 different medications. To help keep these medications appropriately tuned, I use an array of other devices in addition to my diabetes devices that provide critical data about everything from blood pressure and hydration to weight, body fat, activity, sleep, and energy.

If my digital scale indicates I'm dehydrated, I'll likely cut my diuretic dosage in half that day, helping me to avert the inevitable dizziness, neuropathic pain, and continuous glucose monitor (CGM) reading errors that result from dehydration. Later in the day, if I'm better hydrated and my blood pressure goes up as a result, I know to take the rest of that day's dose. If my resting heart rate goes too high, I might cut back on that day's caffeine. If my sleep or activity patterns change, it might mean I neglected to take my anemia drug or that it could be time for an iron infusion.

If these data- and life-informed actions don't right the patterns, I call one of my expert consultants. That can be my endocrinologist, nephrologist, or cardiologist. Armed with the data and an informed sense of what has or hasn't changed, I can markedly improve my consultation with my physician. Our discussion is far more productive, and it's that much easier for my doctor to work with me to identify the necessary action.

> *Each of us is a living, breathing, N of 1 researcher, a participant, and a clinician. Our physicians are there to help, but decisions about how we care for our own life-long illness is both our responsibility and opportunity."*

This is the future of chronic disease management.

A few years ago, I would have said that diabetes patients were different from patients with other conditions — the combined danger of insulin and the development of digital tools put diabetes patients squarely, and uniquely, in charge.

Today, though, many more of our chronic disease–afflicted comrades are following in the path of diabetes patients. The digitally informed patient tribe is growing, as sensors and trackers of various types proliferate. The list of at-home, personal use devices is expanding in ways that are both exciting and daunting. We're already seeing some promising applications for these new tools and sensors, but it will take patients, physicians, and the health care industry a while to figure out what much of this data output means and, importantly, what actions it might inform.

Diabetes patients have had nearly 35 years of experience of living with data. Yet we're still learning new and valuable insights, developing a keen sense of what the patterns mean, then circulating our discoveries directly to other patients. These "N of 1" patient-researchers are completely bypassing the standard clinical research process, sharing their findings immediately and helping fellow patients look for solutions. I suspect this trend will be replicated in other disease communities as more patients become immersed in new, emerging data streams. And if diabetes is a guide post, in due time, those "findings" will make their way to clinical researchers who can begin the process of developing a protocol, securing funding, and conducting the studies to see if these personal findings are valid and applicable for a broader patient population.

When I give presentations or sit on panels discussing these issues, a lot of people like to call me an outlier. They say I am unusually engaged and involved in managing my care. I understand their point, but if they're right, there are a lot of outliers in the type 1 diabetes community. None of us chose this path, but for most of us, the promise that a cure is around the corner has grown stale. We can always hope, but for now we are thankful for the tools and treatments we have that enable us to make data-driven decisions about how to stay alive. Each of us is a living, breathing, N of 1 researcher, a participant, *and* a clinician. Our physicians are there to help, but decisions about how we care for our own life-long illness is both our responsibility and opportunity.

Anna McCollister-Slipp
Chief Advocate for Participatory Research, Scripps Translational Science Institute; Co-founder, Galileo Analytics

Better Communication Makes Better Physicians

Interview

Thomas H. Lee, MD, MSc & Adrienne Boissy, MD, MA

Press Ganey Associates
Cleveland Clinic

Originally published by NEJM Catalyst *http://catalyst.nejm.org/better-communication-makes-better-physicians/*

Adrienne Boissy didn't take no for an answer when she wanted to implement a program to improve communication at Cleveland Clinic. But how much of a need is there to improve communication at one of the leading health care institutions in the world? How do you engage physicians to improve when they already think they're pretty good to begin with?

"Adults choose to learn, or not," Boissy says. "But if you don't have an interest in learning or don't think you have any blind spots, you absolutely won't engage in the learning process."

The Center for Excellence in Healthcare Communication addresses this head on, and with scalable success. The program, intended for experienced physicians, residents, students, and fellows alike, may be 8 hours long, but it's essential for building trust and commitment, even for those who don't think they need to be there.

"Although there is the tendency to try to convince people how important communication skills are, there's actually 30 years of literature that support how important they are, right? In preventing malpractice, safety, quality teamwork, patient satisfaction, as well as physician satisfaction and engagement. And yet, oftentimes, we still feel this responsibility to try to convince people of how important it must be," Boissy says.

Boissy sat down with NEJM Catalyst's Tom Lee to discuss why communication is so important, and how to break down barriers so physicians engage better with one another, with themselves, and ultimately, with their patients. Read or listen to the interview below.

Tom Lee: This is Tom Lee for NEJM Catalyst. I'm speaking today with Adrienne Boissy of the Cleveland Clinic. Adrienne is a good friend and colleague. She's the Chief Experience Officer at Cleveland Clinic. She's an outstanding practicing neurologist, a leader in multiple sclerosis at the clinic. She's been in this very important role, at one of the greatest health care institutions in the world.

I want to start by noting that it's hard to get physicians to change how they do things, particularly when they think things are going pretty well. How are you and the other leaders at Cleveland Clinic getting physicians to be interested in learning new communication skills, as a way of improving their care, when they've got to be thinking they're pretty good to begin with?

Adrienne Boissy: Overall, pretty good to begin with, I think. And thank you for the kind introduction. I would say, we focused on two main points. One is probably a favorite topic of yours, I know, which is about transparency. There's an old educational model from Taylor that talks about medical education and how adults learn. And certainly, adults choose to learn, or not. But it talks about this concept of unconscious incompetence. That if you don't have an interest in learning or you don't think you have any blind spots, you absolutely won't engage in the learning process. And one of the ways to move people out of unconscious incompetence is through transparency, to reflect back to them their blind spots. And that model describes putting them into we call "conscious incompetence," which is this time when you realize, maybe I'm not as good as I thought I was. And only then will people be perceptive to the training or programs about learning, how to be a better communicator.

One of the ways to move people out of unconscious incompetence is through transparency, to reflect back to them their blind spots. And that model describes putting them into we call "conscious incompetence," which is this time when you realize, maybe I'm not as good as I thought I was."

And so that was an important strategic lesson for us as an organization, because putting patient comments about how they felt when you communicated with them, about how effective your language was, and how that made them feel — putting that back at the physicians, and showing them, "this is how patients felt during their interaction with you" — I think is a very powerful way of driving that interest and change.

The second thing is around being willing, in your training, to talk about the cases or the communication challenges that haunt clinicians the most. If you think you don't want to learn about listening or the predictable topics that we talk about in communication skills, that's probably a common phenomenon. But these cases that haunt you, that you remember for the rest of your career as a physician, where you struggled or it left an emotional residue

on you, those are the opportunities to not just maybe do some healing, but to create, and give you new skills to navigate that the next time it pops up. I think that's critically important, because if you're not addressing the sweet spot for clinicians, the learning won't have the impact we want it to.

Lee: You and your colleague, Tim Gilligan, have created a program at the Cleveland Clinic, where physicians all get taught communication skills. And you described it very nicely in your new book, *Communication the Cleveland Clinic Way*. For people who haven't read the book yet, (if there are any out there), can you give a quick thumbnail sketch of what that program looks like? What does it mean for physicians at the Cleveland Clinic?

Boissy: Well, the book is meant to talk about not just the program itself and how it was structured, but as we were rolling out the program, our own doctors taught us a lot about what they needed the most. Meaning, when I started, or seven odd years ago when we were asked to roll out communication skills training, we had no idea what we were doing — we were just "doctors." And we thought a lot about what people would be interested in learning, and what would be relevant and get them engaged in training, and thought about our own experiences. We also made sure we did our homework around learning what evidence-based, best practices were across the country and the globe, as interns and programs that had driven meaningful change in behavior and practice.

> *"There evolved two different agendas in the course. One was to teach content, to be an informative course on effective communication skills. But the second was more transformative, which is this idea that you're changing thinking and attitudes and belief. And much of that was about this context of relationships."*

And so, although the book talks about the content of the program, it also walks people along the journey we took as an organization to shift culture around communication skills, and intentionality around the words we all choose. How do we leverage transparency to raise engagement? How do you invite people to attend and ask them to help, rather than just tell them they have to go? Talking about lessons we've learned around . . . oftentimes, in a course, talking about HCAHP scores or patient satisfaction scores, is not the greatest inspiring force. I think you talk about that a lot, too, in your own work. That putting the scores in front of people doesn't necessarily make them want to change their behavior, in and of itself. So, you have to tap into something deeper and richer that has meaning for them. And I think, the book talks about a lot of those lessons for us as an organization. And building a program that was empathic to our own physicians, just as much as it was meant to drive empathy for our patients. We learned a lot in that process. So, hopefully, the goal of the book is to detail that journey, share some of the lessons we learned, as well as communicate the structure of the course and what our docs taught us about that.

Lee: So, is this a required course for physicians at the clinic? And how many hours does it take?

Boissy: Good question. When we started, we trained thousands — and we're talking about experienced physicians, as opposed to residents or medical students and fellows, at least when we started. When we started, we trained a thousand people by invitation. So, we were very intentional and grassroots about it. So we sent out, maybe, an invitation to about 10 people to say, "Hey, we've got this course, why don't you come take a look?" And then we asked them to suggest 10 additional names. And then, slowly, it spread and trickled throughout, to the point where we were able to train a thousand people just by invitation. And then it hit this critical tipping point where we wanted to make it scalable to the entire enterprise, which was about 4,000 physicians, including residents and fellows. And at that point, we made it an expected requirement of all physicians across the enterprise. And since then, have incorporated it into our ongoing process, as well as into ongoing training for physicians, as more advanced courses have evolved. Again, trying to keep the topics relevant to what's most important to the physicians, that they're most interested in learning in their own practice.

Lee: How big of a time commitment is it?

Boissy: Oh, the full day course is 8 hours. And that number scares a lot of people, as it may scare you, and others who are listening. But the important thing that we pushed back about, when we received some requests to shorten it, was that there are two agendas in the course, or at least there evolved two different agendas in the course. One was to teach content, to be an informative course on effective communication skills. But the second was more transformative, which is this idea that you're changing thinking and attitudes and belief. And much of that was about this context of relationships. What would your language sound like if you were trying to build a relationship with someone, as opposed to just trying to get them to take their medicine? And can we play with that? Can you think about what your role or responsibility in that would be, as a physician?

> *"Putting the scores in front of people doesn't necessarily make them want to change their behavior, in and of itself. So, you have to tap into something deeper and richer that has meaning for them."*

And so, we felt very protective of creating enough space and enough vulnerability over the hours that we were together to get people to that transformative thinking. And throughout the course, in fact, we're very intentional about how we structure exercises and relationships within the course of the day, to deepen the amount of work people have to do. And that requires trust

that we build very intentionally over the 8 hours. So, although it probably is an unheard of commitment, in order to demonstrate the impact, which we ultimately did — [a] statistically significant impact on patient experience, empathy, and burnout — that structure was essential.

Lee: Okay, in everything that I've ever led, it seems like my colleagues split themselves into three groups. There's one group that's really into it. At the other extreme, there's another group that is really not, they're rolling their eyes and they can't believe they're stuck there, they're trying to get out. And then there's a group in the middle that says, okay, I've got to do this, I'm here. What percentages of your docs were in each of those groups? I'm assuming there were representative of all three?

Boissy: Yeah, I think you're right. We had them all, probably. I think what's interesting about your comments is that although the tendency is to try to convince people how important communication skills are, there's actually 30 years of literature that support how important they are, right? In preventing malpractice, safety, quality, teamwork, patient satisfaction, as well as physician satisfaction and engagement. And yet, oftentimes, we still feel this responsibility to try to convince people of how important it must be. And so, when you describe those groups, we probably had, as I said, a thousand people. So, literally, up to, I would say, 25, 30 percent of people of our entire staff went through the entire course, completely voluntarily, just by invitation. I think that's a highly engaged group. I would say there's a majority in the middle, who engaged, thinking that there was some relative benefit to them.

And I would say the degree that were actively disengaged is probably somewhere around the range of 5 to 10 percent. And the reason I say that [is that] we talk about in the book [how] there were two people we had to pull aside at some point and say, "Wow, this really seems to be a struggle for you," or, "Tell me a little bit about how you think your behavior might be impacting the rest of the group." Because I think all of us, too, need to be aware that even if we don't think it's important, there are lots of other people at the table who probably could derive something. It was a very interesting finding in the study that no matter how many years of training you'd had, no matter what your patient satisfaction scores coming in were, no matter what specialty you were in, everyone who went through the course became better. And I think that's an important lesson. That all of us have something to learn. And when people said, "I don't need to come, I've been teaching communication skills in the medical school for five years," we said, "That's great. We need your talent in the room just as much as someone who hasn't been doing that." And so, you just have to meet people where they are and we were pretty intentional about doing that.

Lee: One of my very favorite parts of your book was how you wouldn't take no from the Chair of Neurosurgery. He wanted to pawn the role of leading this off on some new person and you wouldn't take no. Can you quickly summarize that little vignette? Why you wouldn't take no, and how things worked out?

Boissy: Sure. So, for anybody who may not have met me before, I am a relatively young female. And I, at the time, was exquisitely aware that communication skills training could be viewed as a soft and fluffy skill that perhaps only some of us need or believe in. And I was very interested, at the time, in choosing people who had [what] we hear called "nodes" or "organizational influence," and "longevity." And I had very intentionally chosen people from across the organization who I thought can bring that as facilitators for the training. People who had been here for 30, 40 years. People who were surgeons; if your organization is 60 percent surgeons, you need to have that represented in your facilitator pool. So, I wanted, again had thought and strategized, about who would serve best as facilitators for a variety of reasons.

> *It's very important to us to model the skills that we're talking about, in the experience of the course itself, so that you, as a participant, feel what it feels like, to be listened to, to have empathic curiosity land on you, to be a part of what happens the rest of the day."*

I went to the Chair of Neurosurgery and said, "I'd really like you to be involved in this effort. I think this is a part of who you are," as well as, "You could be a very powerful influence on many others, in terms of turning this tide." And, as you mentioned, he wrote back saying, "That's very nice. I appreciate that you thought of me. There's a young woman who recently joined our practice. I think she might be better. I think this would be perfect for her." And I think I wrote back and said, "I appreciate your suggestion, and I'd still like you to do it."

While he was thinking that over, I had engaged the institute chair. So I give him a lot of credit at the time. And I just said, "I don't want a younger person, and I certainly don't want a female. I'm being very strategic about who has organizational influence here, and I think he's the right person." And [I] garnered support, and as I often say, was relentless in my pursuit, I think, to make sure that was brought to bear, and trusted my gut on that.

And to be honest, it was absolutely the right choice. People often come to me and say, "I wouldn't have come to the course, except I heard what you did with Dr. _____. I can't believe you got Dr. So-and-So to teach the course." That word of mouth has a very powerful effect on the rest of your organization. You can't underestimate that power of one person who is that node, that sphere of influence.

Lee: I love that story. Now, all right, I trust you. My personal assessment of myself is that I'm a pretty good communicator. I am not a doctor at Cleveland Clinic, but if I was there and I acknowledge that as good as I might be, I could get better, what would happen to me during that 8-hour course?

Boissy: Is that even possible, for Dr. Tom Lee to get better? You're already so good, Tom, I'm not sure that we could make any inroads. I'm just kidding. So, I think, if you came into the course, you would be greeted immediately, and we would engage you, likely, in a discussion about who you are as a person, and your prior experience with communication skills training. It's very important to us to model the skills that we're talking about, in the experience of the course itself, so that you, as a participant, feel what it feels like, to be listened to, to have empathic curiosity land on you, to be a part of what happens the rest of the day — shared decision-making. And we build that into your experience as a participant.

> *No matter how many years of training you'd had, no matter what your patient satisfaction scores coming in were, no matter what specialty you were in, everyone who went through the course became better. And I think that's an important lesson. That all of us have something to learn."*

We ask you if you've been up all night, on call. We introduce some play and some fun, so you're interacting with colleagues early. But it's not just superficial questions. It's questions driven with meaning: "Have you had a difficult conversation within the last week? Have you lost a patient?" We're exploring that very early, to try to raise the amount of trust and vulnerability in the room fairly quickly.

As we go through the course, we'll ask you to bring your toughest communication scenarios: "I want you to think about that. I want you to tap into that space where you struggled." And we'll ask you about that, Tom. And then, we'll assess your level of comfort throughout the day. "Is the learning getting too much? How is the feedback landing on you? Are you engaged in the learning process or not?" And oftentimes, at the end of the course, we'll ask you to appreciate other members who took the course with you, to end on a note of gratitude. And certainly, to reflect on what's one thing that you're going to take away and use, every single day, in either patient interactions or interactions with your colleagues. So, our real goal is to build an experience for you that you walk away talking about for a long time.

Lee: Well, the word of mouth I hear is that you've been successful. The data, as you described, indicate that it has had real impact that's measurable. And I can tell you that the fact that you guys started this program and implemented it across the system, at Cleveland Clinic — one of the flagship institutions of the country — is attracting a lot of attention. I actually think you're changing health care. And spreading word about that

is part of our job with Catalyst. So, I want to thank you for your time today, thank our audience for listening, and I'm sure there are going to be more lessons learned in this and other areas, by you, in years to come. And I'm looking forward to staying in touch and bring you back to the Catalyst audience, as well. Thank you very much, Adrienne.

Boissy: Thank you very much, Tom.

Thomas H. Lee, MD, MSc

Press Ganey Associates

As Chief Medical Officer for Press Ganey Associates, Inc., Dr. Lee is responsible for developing clinical and operational strategies to improve the patient experience for health care providers across the nation. Learn more about Thomas H. Lee...

Adrienne Boissy, MD, MA

Cleveland Clinic

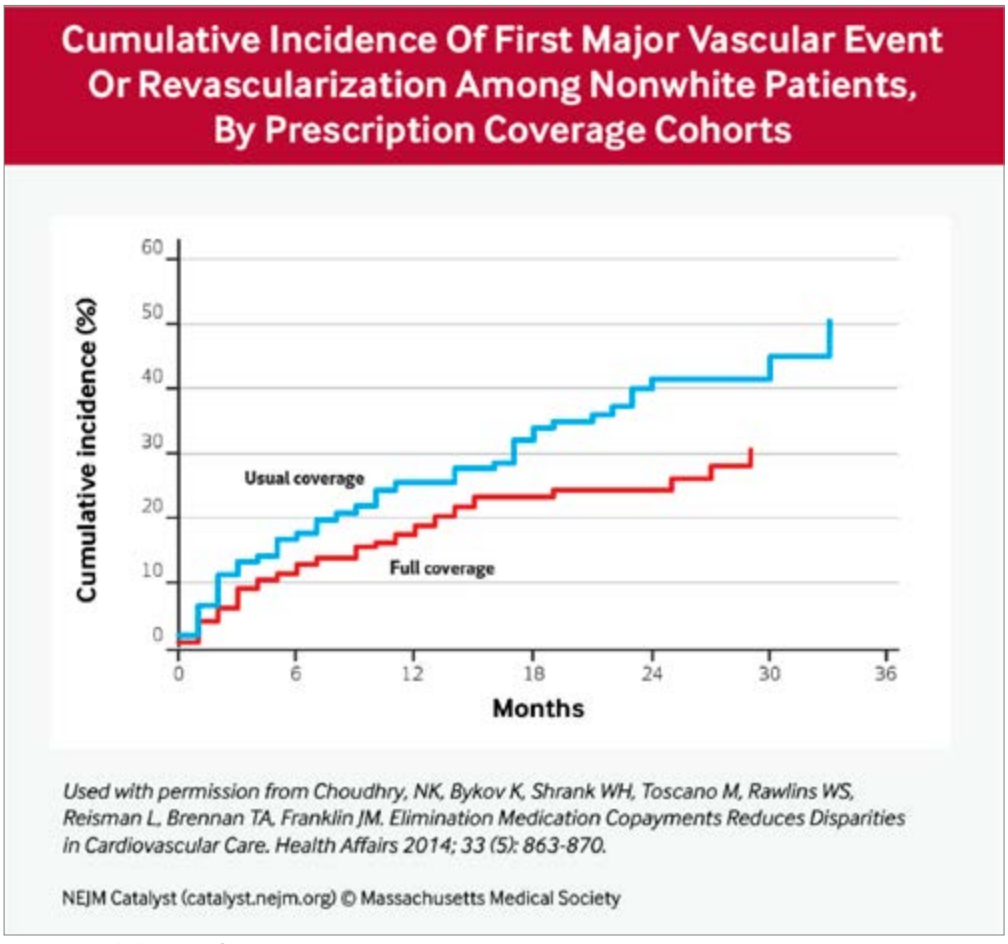
Adrienne Boissy, MD, MA, is Chief Experience Officer of Cleveland Clinic Health System, and a staff neurologist at the Cleveland Clinic Mellen Center for Multiple Sclerosis. Learn more about Adrienne Boissy...

My Favorite Slide: One Size Does Not Fit All in Behavioral Interventions

Blog Post

Kevin Volpp, MD, PhD

Originally published by NEJM Catalyst *http://catalyst.nejm.org/one-size-does-not-fit-all-in-behavioral-interventions/*



Kevin Volpp's Favorite Slide.

This is one of my favorite slides because it highlights how behavioral interventions can have very different effects in different portions of the population. MI FREEE was a randomized controlled trial in which Aetna waived copayments for all patients hospitalized with heart attacks. The trial showed that overall adherence to evidence-based therapy in the year following a heart attack is poor: 39% in the control group, 45% in the "free medication" group. Among African-Americans and Hispanics, however, the effects of the trial are striking — rates of major vascular events or revascularization dropped by 35% and total health care spending declined by 70%. These outcomes suggest that we need to think more about how innovations in benefit design may have different effects in different populations. Over time, this should lead to recognition that the typical approach to benefit design — one size fits all — may not be optimal.

Kevin Volpp, MD, PhD

Perelman School of Medicine, University of Pennsylvania

Kevin Volpp is the Director of the Center for Health Incentives and Behavioral Economics; Vice Chairman for Health Policy, Medical Ethics, and Health Policy; and Professor of Medicine, Medical Ethics and Health Policy and Health Management at the Perelman School of Medicine and the Wharton School at the University of Pennsylvania. Learn more about Kevin Volpp...

Patient Engagement Survey: Far to Go to Meaningful Participation

Insights Report

Kevin Volpp, MD, PhD & Namita S. Mohta, MD

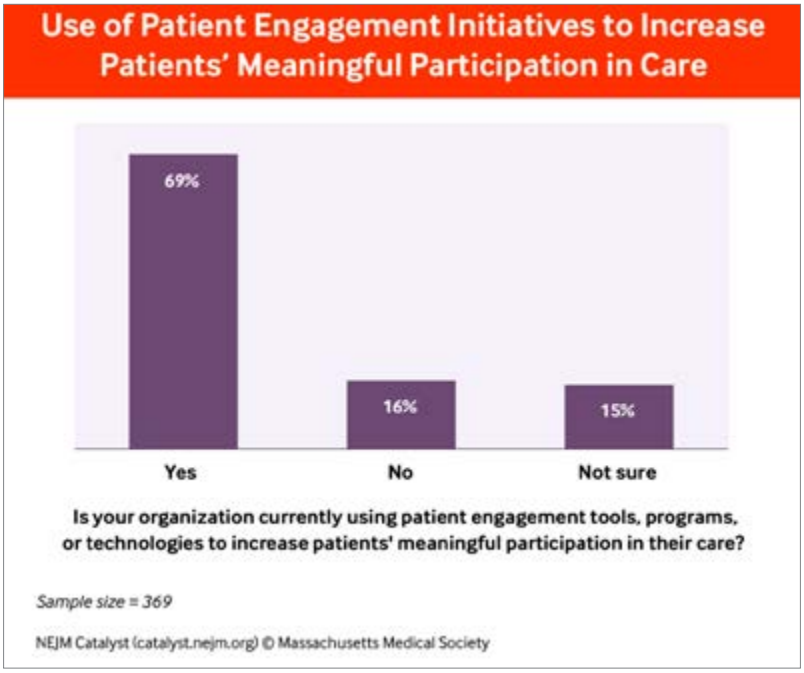
University of Pennsylvania
NEJM Catalyst; Brigham and Women's Hospital

Originally published by NEJM Catalyst *http://catalyst.nejm.org/patient-engagement-initiatives-survey-meaningful-participation/*

Analysis of the second NEJM Catalyst Insights Council Survey on the Patient Engagement theme. Qualified executives, clinical leaders, and clinicians may join the Insights Council and share their perspectives on health care delivery transformation.

The foundation has been laid for exciting advances in patient engagement, according to the second NEJM Catalyst Patient Engagement Survey. With fundamental patient engagement strategies such as patient portals and secure email firmly in place, health care organizations are now turning to Patient Engagement 2.0 — initiatives that will get patients even more involved in their care.

The survey was fielded to gauge participation in, and effectiveness of, patient engagement across health systems, hospitals, and physician organizations. More than 69% of respondents report that their organizations use patient engagement initiatives to increase patients' meaningful participation in care.



Patient Engagement Insights Report.

This percentage presents somewhat of a Rorschach test, however. Ideally, as health care providers head toward more widespread value-based care, the number using patient engagement initiatives should be far closer to 100%. As an industry, we obviously have more work to do to demonstrate that providers should be engaging and supporting patients outside of direct health care encounters.

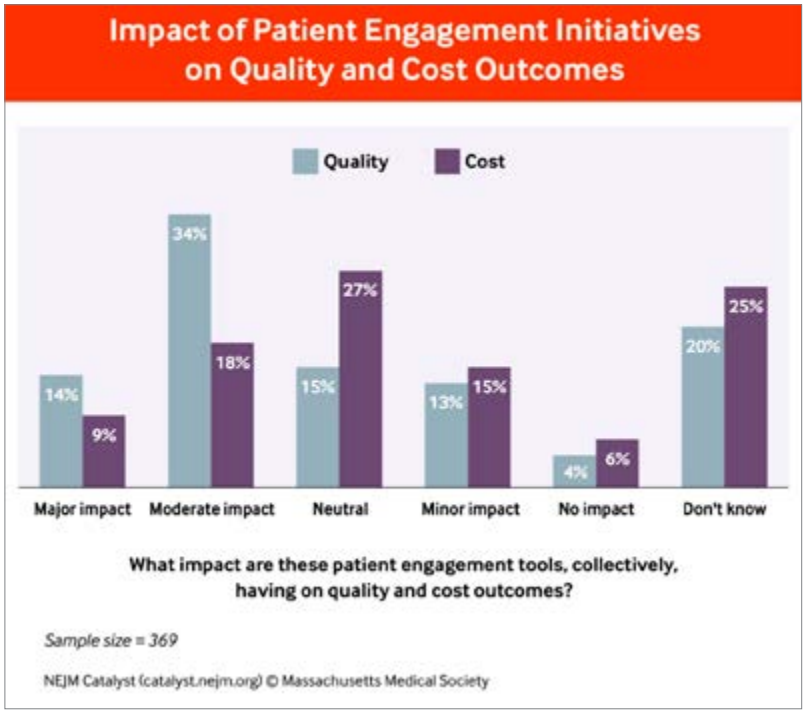
> *While 68% say they are currently using or have plans to implement patient-generated data, only 34% are currently using it at scale."*

Consider the 5,000-hour problem. In the 2012 *New England Journal of Medicine* article, "Automated Hovering in Health Care — Watching Over the 5000 Hours," we noted that although patients spend only a few hours a year with a doctor or nurse, they spend 5,000 waking hours each year engaged in everything else, including deciding whether to take prescribed medications, choosing what to eat and drink and whether to smoke, and making other choices about activities that can profoundly affect their health.

How do clinicians make a dent in prevention if you have only a few hours in front of a patient? Many survey respondents comment that we need to engage patients outside the exam room with frequent, creative interactions that do not have to always include their physicians.

Much Room to Improve Patient Engagement

Nearly half of respondents to the NEJM Catalyst Patient Engagement Survey say their patient engagement initiatives are having a major (14%) to moderate (34%) impact on quality outcomes. That's pretty remarkable considering we are still in the earlier stages of patient engagement and that many potential approaches have yet to be fully scaled and integrated into practice. Interestingly, clinical leaders (60%) feel more strongly than executives (47%) and clinicians (43%) that their efforts to engage patients are working.



Patient Engagement Insights Report.

More than a third of respondents say portals are the most effective form of patient engagement. Secure email is a distant second at 14%.

Patient Engagement Insights Report.

Survey respondents clearly think the best is yet to come — Patient Engagement 2.0.

For instance, while 68% say they are currently using or have plans to implement patient-generated data, only 34% are currently using it at scale, leaving 13% in pilot stages and 22% planning for it in the next 24 months. Patient-generated data is health-related data created, recorded, or gathered by or from patients (or family members or other caregivers) to help address a health concern. For instance, patients could share the results of their blood glucose monitoring, blood pressure readings, or exercise programs.

> *Care coordinators seem to be the litmus test for organizations to prove they are serious about patient engagement."*

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VERBATIM COMMENTS FROM SURVEY RESPONDENTS

What is the most creative way you know of to enhance patient engagement?

"Promote clinician wellness, prevent burnout, and avoid grumpy bosses who make you feel like your job is in jeopardy."

— Executive at a health system in the mid-Atlantic

"Nursing care conferences with patient, family, and multidisciplinary team, plus PCP."

— Service Line Chief at a midsized for-profit health system in the South

"Look them in the eye and not have a computer in the room."

— Physician at a large for-profit physician organization in the mid-Atlantic

"Using multiple avenues of approach to patients and home caregivers to enable them to provide enhanced self-care."

— Vice President of a large nonprofit health system in the Midwest

"It's not creative, but simply having the provider call [the] patient and discuss health issues."

— Chief Medical Officer of a large for-profit physician organization in the South

(CONTINUED ON NEXT PAGE)

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VERBATIM COMMENTS FROM SURVEY RESPONDENTS (CONTINUED)

"Patient engagement is enhanced most effectively by attentively listening and constantly adapting to each individual's needs, expectations, and abilities. I am a big proponent of advanced technology, however, no fancy electronic tool or gimmicky wearable wireless device will ever be able to increase patient engagement to the same degree as developing a solid physician-patient relationship."

— Clinician at a midsized teaching hospital on the Pacific coast

"Deploying the full spectrum of communication: patient education prior to discharge, follow-up phone calls after discharge, follow-up email with health and wellness tips related to the patients' specific conditions."

— Executive at a midsized nonprofit community hospital in the mid-Atlantic

"Intensive education of a patient on Etiology of their disease, Effectiveness of latest care, Efficiency with comparative affordability of the care, and parameters of Quality-of-Life outcome prognosis SHOULD ALWAYS BE PRESENTED at the First Encounter with a Physician and/or Surgeon. This paradigm has worked for me in the past 36 years of med-surg practice."

— Service Line Director at a for-profit health system in the South

"Quantifying their life — sleep tracker, calorie tracker, step and exercise logging, symptom diary. If this could be integrated into an EHR and updated from a mobile device, that would be amazing."

— Physician at a midsized for-profit clinic on the Pacific coast

(CONTINUED ON NEXT PAGE)

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VERBATIM COMMENTS FROM SURVEY RESPONDENTS (CONTINUED)

"Open, honest, respectful conversation and being fully present with all encounters."

— Vice President of a large nonprofit health system in the Midwest

"Multidisciplinary team rounds. The patients hear the plan for the day, have the opportunity to ask questions, and know that all members of the team are communicating. Patient family members know when rounds begin, and are often present as well."

— Physician at a midsized for-profit community hospital in the Mountain West

"Patient portal."

— Vice President of Medical Affairs at a large nonprofit community hospital in the South

Likewise, social networks are only 31% at scale today, with 26% in pilot or planning stages, according to the survey. Social networks use the patient's support network, including family and community, to create positive, sustained behaviors. For instance, a provider could offer family cooking classes to influence better nutrition for diabetic patients.

Status of Patient Engagement Initiatives

	Currently using or plans to implement (Net)	Currently using at scale	Currently using on a pilot basis	Plan to implement within next 12 months	Plan to implement in 13-24 months	Not using and no plans to implement in next 24 months
Patient portal	88%	71%	8%	5%	4%	12%
Secure email	77%	59%	9%	4%	5%	23%
Online/mobile scheduling (including reminders)	72%	38%	11%	13%	9%	28%
Patient-generated data (such as within an EHR)	68%	34%	13%	10%	11%	32%
Social networks	58%	31%	13%	9%	4%	42%
Wireless/wearable devices	47%	16%	13%	8%	10%	53%
Intra-office tools (such as group visits)	46%	17%	12%	10%	7%	54%
Benefit design	39%	17%	6%	8%	7%	61%

Please indicate the status of each of the following patient engagement tools, programs, or technologies at your organization.

Sample size = 369

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Patient Engagement Insights Report.

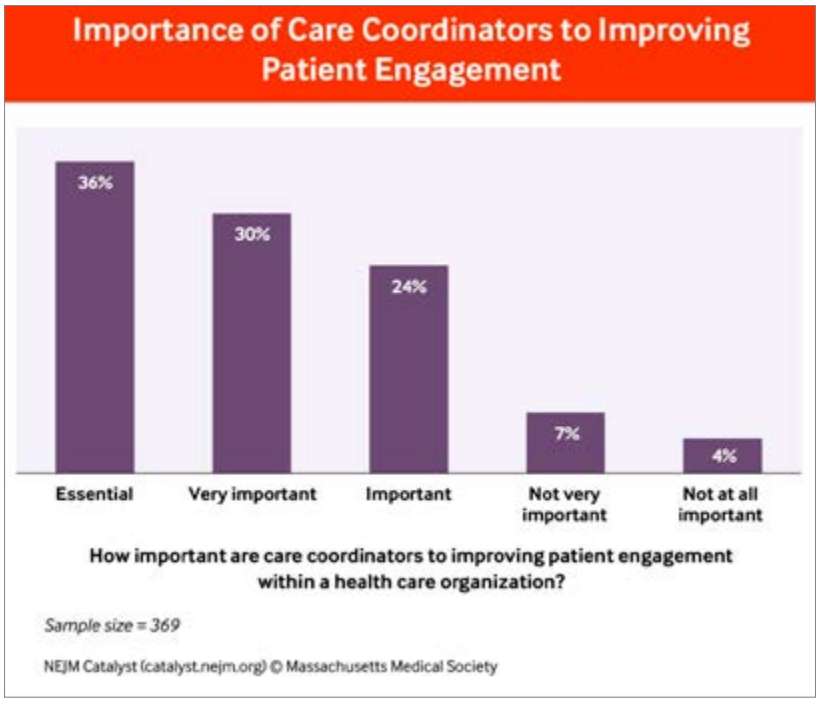
Wireless/wearable devices (such as heart rate monitors or activity trackers) are used at scale by only 16% of respondents, but 31% say they are in pilot or planning phases. The proliferation of these technologies should result in greater competition and lower cost from vendors.

> *With the shift to value-based payment models, there may be more of an imperative to design and test new ideas to engage patients between visits that will improve both cost and quality."*

However, provider organizations must make significant strides in assimilating the large amounts of data generated by these devices into clinicians' daily workflow.

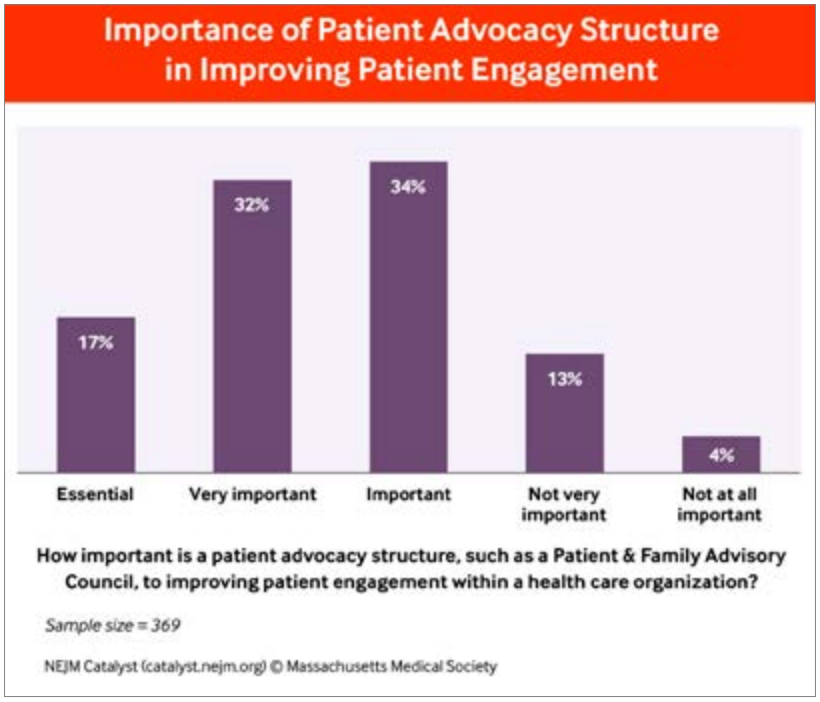
Benefit design, which 17% of respondents are using at scale as a tool for patient engagement, is listed by 21% as in pilot or planning stages. Providers plan to restructure patient benefits to align with intended behaviors, such as decreasing required co-pays for smoking cessation classes or insulin education visits for diabetics. Co-pays traditionally are meant to deter overutilization, but providers must align their patients' best interests — for example, getting diabetes under control — with the design of benefits.

These anticipated initiatives could help boost the cost impact of patient engagement as well. Fewer than 10% of survey respondents say their current patient engagement initiatives have a major impact on cost, and fewer than 20% note a moderate impact. With the shift to value-based payment models, there may be more of an imperative to design and test new ideas to engage patients between visits that will improve both cost and quality.



Patient Engagement Insights Report.

As further proof of the need to engage patients between visits, 90% of respondents say care coordinators are essential (36%), very important (30%), or important (24%) in improving patient engagement. Care coordinators seem to be the litmus test for organizations to prove they are serious about patient engagement. Respondents are less bullish about a patient advocacy structure such as Patient and Family Advisory Councils, with less than a fifth calling it essential.



Patient Engagement Insights Report.

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Who Will Lead Patient Engagement?

So who will lead the charge to Patient Engagement 2.0? According to our survey, it depends on whom you ask. Executives and clinical leaders say the Chief Medical Officer is best equipped to head up this challenge, while clinicians say staff physicians should take the helm. Overall, CMOs ranked highest at 38%, followed by staff physicians (35%) and staff nurses (23%).

Patient Engagement Insights Report.

No matter who takes on the responsibility of getting to the next level of patient engagement, they must be innovative enough to strengthen the foundational elements and to build the next wave of initiatives that will improve outcomes and experience for our patients.

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METHODOLOGY AND RESPONDENTS

- In July 2016, an online survey was sent to the NEJM Catalyst Insights Council, which includes U.S. health care executives, clinician leaders, and clinicians at organizations directly involved in health care delivery. A total of 369 completed surveys are included in the analysis. The margin of error for a base of 369 is +/- 5.1% at the 95% confidence interval.

- The majority of respondents were clinicians (53%), with executives (22%) and clinician leaders (25%) nearly evenly split. Most respondents described their organizations as hospitals (40%) or health systems (15%). These hospitals were predominantly midsized (33% had 200–499 beds) or larger (47% had 500 or more beds).

- Only 9% of respondents indicated that their major affiliation was with a physician organization. Those physician organizations tended to be big — 47% had 100 or more physicians.

- More than two-thirds of the organizations (68%) were nonprofit, with the remainder of respondents coming from for-profit organizations. Every region of the country was well represented.

Check NEJM Catalyst for monthly Insights Reports not only on Patient Engagement but also on Leadership, the New Marketplace, and Care Redesign.

Join the NEJM Catalyst Insights Council and contribute to the conversation about health care delivery transformation. Qualified members participate in brief monthly surveys.

Kevin Volpp, MD, PhD

Perelman School of Medicine, University of Pennsylvania

Kevin Volpp is the Director of the Center for Health Incentives and Behavioral Economics; Vice Chairman for Health Policy, Medical Ethics, and Health Policy; and Professor of Medicine, Medical Ethics and Health Policy and Health Management at the Perelman School of Medicine and the Wharton School at the University of Pennsylvania. Learn more about Kevin Volpp...

Namita S. Mohta, MD

Clinical Editor, NEJM Catalyst; Faculty, Center for Health Care Delivery Sciences and Academic Hospitalist, both at Brigham and Women's Hospital

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